Riverside Medical, S.C.
Internal Medicine and Gastroenterology

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PATIENT COMMUNICATION AGREEMENT

Patient's Name: Last First Middle Initial _____/____/_____ Date of Birth

Address City State Zip Code

Phone: (_____)_____ (_____)_____ (_____)_____
Home Work Cell

Which # do you prefer communication? ☐ Home ☐ Work ☐ Cell

In accordance with HIPAA, please answer the following questions:

May we leave messages on your voice mail or answering machine? ☐ Yes ☐ No

May we leave messages with any other person and/or do you authorize any other person to call regarding your medical information? ☐ Yes ☐ No

If Yes, with whom? _____ Relationship_____ (_____)_____
Phone

If Yes, with whom? _____ Relationship_____ (_____)_____
Phone

May we call you at work? ☐ Yes ☐ No

Emergency Contact: _____ Relationship:_____ (_____)_____
Phone

Pharmacy of Choice:_____ Town and Street of Pharmacy:_____

We are now offering "Guest Pay" for online payments. No more logging in. You are also able to receive E-Statements (email) instead of a paper statement.

I elect to receive my statement via email: ☐ Yes ☐ No

Your Email address is required for us to set-up your login to our patient portal.

The patient portal allows you to securely communicate with our staff. You can:

- Send messages to and from the practice.
- Request refills on your medication.
- View lab reports.
- Request appointments.
- Remit Patient balances on our secure portal.

Do you want access to the Patient Portal and have the ability to utilize its features? ☐ Yes ☐ No

If yes, Email Address: _____

PLEASE TURN OVER

3405 N. Arlington Heights Road, Arlington Heights, IL 60004
847.577.9300 Fax: 847.577.9318 www.riversidemedicalsc.com

Please initial each section. **PATIENT NAME** _____

_____**(Initial)** I understand there is a $25.00 **"No-Show" and/or "Late Cancellation Fee"** if I do not provide a minimum of 24-hours' notice of my intent not to appear at a scheduled appointment. If the appointment is for a **Wellness or Physical Examination**, I understand the fee for **"Late Cancellation" or "No Show" is $50.00.**

_____**(Initial)** I hereby authorize Riverside Medical, S.C., to release to my insurance company, third party insurance, or their medical review companies, all medical information necessary to secure payment of medical services. I hereby authorize payment of all medical/surgical insurance benefits, to be directly to Riverside Medical, S.C. **I understand I will be fully responsible for payment of any and all charges not covered by medical insurance, such as copayments, deductibles and coinsurance, and for services I have signed a prior agreement to be responsible for if not covered by my insurance.**

_____**(Initial)** Payment for services may be made by credit card, approved check, or cash. **Returned checks will be issued a $35.00 return fee.**

_____**(Initial)** **UNPAID BALANCES AFTER 60 DAYS WILL BE SUBJECT TO $25.00 PER MONTH LATE FEE.** Accounts 4 months and older, may require **COLLECTION AGENCY ACTION** if an agreement between Riverside Medical and myself has not been formally arranged. **ALL COLLECTIONS FEES WILL BE MY (PATIENT) RESPONSIBILITY.**
IN THE EVENT YOUR ACCOUNT IS SENT TO COLLECTIONS, THE COLLECTION FEE OF $100.00 WILL BE ADDED TO YOUR ACCOUNT.

_____**(Initial)** **INSURANCE POLICIES DETERMINE MEDICAL COVERAGE.** THERE ARE MANY DIFFERENT PLANS, INDEPENDENT OF EACH OTHER, WITHIN THE SAME INSURANCE COMPANY. **IT IS MY (PATIENT) RESPONSIBILITY TO UNDERSTAND MY MEDICAL COVERAGE INCLUDING BUT NOT LIMITED TO: (1) DEDUCTIBLES. (2) COINSURANCE AND COPAYMENTS. (3) SERVICES THAT REQUIRE A REFERRAL. ANY SERVICES, OR REFERRALS RECOMMENDED BY OUR DOCTORS ARE MADE STRICTLY FOR MEDICAL PURPOSES.**

WELLNESS COVERAGE – According to the American Medical Association and your insurance, the Term "Wellness" only includes –

1. Age and Gender specific history and examination.
2. Risk factor reduction interventions such as Vaccines, Mammograms, Prostate Screening, and Pap Smears.
3. Certain Laboratory tests. (Does not apply to Medicare Patients.)

_____**(Initial)** **A Wellness visit/Well check is not a Complete Physical Examination and DOES NOT include the Evaluation and Management of Chronic Conditions or Acute Illnesses. A separate office visit will be charged for any condition that requires review, continuous treatment, advice and/or diagnosis.**

PRIVACY POLICY

The HIPAA notice has been made available to me by Riverside Medical, S.C.

My signature is confirmation that I understand, and initial each section listed above.

Signature _____ Date _____

Patients will have 60 days to review and remit payment on outstanding balances. After 60 days, a $25.00 Late Charge will be applied. Any dispute of balance must be made no later than 60 days from the date of service, or 60 days from the date your insurance makes final adjudication of your claim. After 90 days, unpaid balances will automatically be charged to your credit card account.

REQUIRED CREDIT CARD# _____ Expiration Date ___ / ___ / ___ Authorization Code: _____
(3 digits on back side of card.
If Am Ex. 4 digits on front)

Signature _____ Date _____