|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **PATIENT INFORMATION** | | | | | | |
| **Last Name (Legal):** | **Date of Birth:** | | | | **Sex Assigned at Birth:**  □ Male □ Female | **Social Security #:** |
| **First Name (Legal):** | **Middle Initial:** | | | **Responsible Party:** □ Self  □ Other (see below) | | |
| **Preferred Name:** | **Pronouns:** | | | **Preferred Language**   * English □ Spanish Other (please specify): | | |
|  |  | | |
|  | | | |
| **Address:** | | | |
|  | | | |
| **City:** | **State:** | **Zip:** | | **Interpreter Needed:**   * Yes | | |
| **Home Phone #:** | **Cell Phone #:** | | | **Email Address:**  **(Your email will be used to sign you up for the patient portal.)** | | |
| **Primary Care Provider:** | | | **Referring Provider:** | | | |
| **Patient Race:**   * Asian * Native Hawaiian/ Other Pacific Islander * More Than One Race * Black/African American * American Indian/Alaska Native * White * Refuse to Report * Other Race: | **Patient Ethnicity:**   * Hispanic/Latino * Non-Hispanic/Latino * Refuse to Report * Other: | | | **Answer the following as yourself or as parent if patient is a minor:**  Are you the biological parent of the patient/minor?  Yes □ No  □ No, but I am the legal guardian/medical decisionmaker & could provide documentation | | |
| **Preferred Pharmacy:** | | | | | |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **RESPONSIBLE PARTY □ Check if same as patient** | | | | | | | | |
| **Last Name (legal):** | | **First Name (legal):** | | **MI:** | **Preferred Name:** | | **Relationship:** | |
| **Date of Birth:** | **Social Security #:** | **Personal Phone Number:**  **Work/Alt Phone Number:** | | | | **Email Address:** | | |
| **Address:**  Same as above | | **City:** | | | **State:** | | | **Zip:** |
| **INSURANCE NAME:** | | **ID #:** | | | **GROUP #:** | | | |
| **MEDICARE                                          MEDICARE ADVANTAGE PLAN                          STATE MEDICAID**      **MEDICARE SUPPLEMENT              COMMERCIAL INSURANCE                                  NO HEALTH INSURANCE** | | | | | | | | |
| **ADDITIONAL PARENT/GUARDIAN INFORMATION** | | | | | | | | |
| **Last Name (legal):** | | **First Name (legal):** | | **MI:** | **Preferred Name:** | | **Relationship:** | |
| **Date of Birth:** | **Personal Phone Number:**  **Work/Alt Phone Number:** | | **Email Address:** | | | | | |
| **Address: Same as above** | | | | | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **EMERGENCY CONTACT(S) □ Check if same as responsible party** | | | | |
| Please list at **least one individual(s) not living with you** that we could contact in case of an emergency. I authorize FVMA to share my personal health information with the person(s) below. I understand this authorization is voluntary. I understand that once my information is disclosed, it may be disclosed by the recipient, and the information may not be protected by Federal privacy laws or regulations. I understand this consent will remain in effect until I cancel it in writing. | | | | |
| **Name** | **Relationship to Patient** | **Phone** | **Email address, if granting access to your patient portal** | **Authorization** |
|  |  |  |  | * All * Scheduling Only |
|  |  |  |  | * All   Scheduling Only |
|  |  |  |  | * All   Scheduling Only |
|  |  |  |  | * All   Scheduling Only |

* **I decline to provide an emergency contact.**

# FOR PATIENTS UNDER AGE 18 ONLY

I, AS THE PARENT/LEGAL GUARDIAN OF THE MINOR AGED PATIENT, AGREE TO ALLOW THE FOLLOWING PERSONS TO GIVE CONSENT FOR THE TREATMENT OF SAID MINOR:

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **DOB** | **Relationship to Minor** | **Contact Information** |
|  |  |  |  |
|  |  |  |  |

Signature: Printed: Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **CONSENT FOR EVALUATION AND TREATMENT** |
| I voluntarily consent to, and authorize care from, Fox Valley Medical Associates (FVMA) and its medical, nursing, and other professional staff members, to provide such services and administer diagnostic and therapeutic procedures and treatments as is deemed necessary or advisable in my care by the licensed personnel. This encompasses all diagnostic and therapeutic treatments considered necessary or advisable by the health care provider (HCP) including routine tests and procedures, routine immunizations, withdrawal of blood, testing for Hepatitis B and C, HIV, and labs. In the event my blood and/or body fluids is suspected to have come in direct contact with any health care worker, I consent to appropriate labs (to determine if my body fluids have contagious viruses). I understand that all patients will see an HCP or a nurse, and that FVMA is a teaching facility in which any cases may be used to instruct pre-med, medical, nursing, or medical assistant students or residents. All student evaluations are under the direct supervision of the attending licensed provider. I consent to the taking and use of clinical photographs for diagnosis, treatment, and healthcare operations, with the understanding that all images will be kept confidential and used in accordance with applicable privacy laws. If patient is a minor, I voluntarily consent to comprehensive healthcare services for myself or my child(ren). I understand that if I am 12 years of age or older, I may consent for certain types of health services, including mental health services; if I am 18 years of age or older, I must consent for all other health services myself, unless my parent or legal guardian has the legal authority to do so. By signing this form (parent or legal guardian signature, if required), I agree that I have read or had this form read and/or explained to me, that I understand it and that any questions I asked have been answered. I understand that I agree to be truthful in providing information. Thus, I hereby ask, agree, and consent to evaluation and treatment for myself and/or child(ren) as set forth above, including any procedures that FVMA professional staff decide are necessary or appropriate. If signing as parent or guardian, I hereby represent and warrant that I am legally empowered and entitled to make such decisions. |
| **AUTHORIZATION TO RELEASE MEDICAL INFORMATION** |
| I hereby authorize FVMA to release any information necessary for the course of my treatment, obtain payment for services, and to perform business operations such as quality assurance, service planning, and general administration. I understand that this authorization may include information about HIV or AIDS, alcohol or drug use, mental illness or any mental health condition, sexually transmitted disease, family planning, pregnancy, and/or genetic tests or genetic disease. I understand that my records are protected by HIPAA regulations and cannot be disclosed without my written consent at any time unless otherwise provided for in the regulations and except to the extent that action has already been taken in reliance upon it, by given written notice to FVMA. |
| **AUTHORIZATION OF PRESCRIPTION MANAGEMENT** |
| I authorize FVMA to track my medications from all providers past and present in order to document allergic reactions, adverse side effects, dosages, and other pertinent information to ensure proper treatment and management of my health care. |
| **NON-COVERED SERVICES & CO-PAYS** |
| As your health care provider, our relationship is with you and not your insurance carrier. We will file your claim to your insurance; however, **you are the sole responsible party for all charges that remain after insurance payments**. You will be responsible for your payment portion at the time of service. Failure to provide FVMA with current, accurate insurance information will result in all charges for services becoming the responsibility of the patient/responsible party. **All co-pays, co-insurance, and deductibles are due at the time the services are performed. For patients with Medicare or Medicaid, please be advised there may be an applicable co-pay for services rendered. If we are not contracted with your insurance company, you will be 100% responsible for the payment at the time of service**. When you receive care services, you have the right to clear and upfront information about costs—even when paying out-of-pocket. Under the No Surprises Act, patients who are uninsured or self-pay are entitled to a Good Faith Estimate (GFE) of the expected charges for your visit or treatment and the ability to dispute a bill that is $400 or more above the provided estimate. This protection applies to scheduled, non-emergency visits such as routine check-ups, vaccinations, screenings, follow-up appointments, and chronic condition management at Fox Valley Medical Associates. |
| **OUTSIDE LAB & X-RAY FEES** |
| Labs drawn at FVMA will be processed by FVMA, or Quest. **If your labs are processed by Quest, you will receive a separate bill from Quest in the mail**. For any other orders sent out (including X-rays), you will separate bill from that facility. If you are uninsured and have labs sent to Quest, please ask to speak to the billing department for more information.   |  | | --- | | **TELEHEALTH CONSENT** |   I also consent to services via secure telehealth (video or phone). I understand: I may decline or stop telehealth anytime; It may involve risks (e.g., tech issues), but FVMA takes steps to protect privacy; Telehealth may be billed like in-person visits.   |  | | --- | | **NOTICE OF PRIVACY PRACTICES & CONSUMER RIGHTS** |   I acknowledge FVMA’s Notice of Privacy Practices, Patient Bill of Rights, and Patient Non-Discriminatory Policy, these were made available to read. |

I consent to the statements above.

Patient/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Printed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_