M.Chávez MD, SC
PROCEDURAL MEDICINE • AUTHENTIC CARE

New Patient Registration Form

PATIENT INFORMATION:

Last Name **First Name** **M.I.** **Date of Birth**

Street Address **Apartment** **City** **State** **Zip Code**

☐Male ☐Female **Social Security Number** ☐Single ☐Married ☐Divorced ☐Widowed

Ethnicity: ☐Hispanic ☐Non-Hispanic Race Preferred Language

Area Code **Home Phone** **Area Code** **Mobile Phone** **Email address (required)**

Preferred Method of Communication: ☐Home Phone ☐Mobile Phone ☐Email

PHARMACY INFORMATION:

NAME **Phone**

Street Address **City** **State** **Zip Code**

EMERGENCY CONTACT:

Name **Relationship** **Phone**

AUTHORIZATION AND RELEASE:

I authorize the release of any information, including the diagnosis and the records for any treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services; I agree to be responsible for payment of all services rendered on my behalf or my dependents.

SIGNATURE OF PATIENT or Parent (if Minor) **Date**

1509 N. Western Ave. Unit - A, Chicago, IL 60622; Phone: (773) 227-3303; Fax: (773) 897-5848
info@mchavezmd.com

M.Chávez MD, SC
PROCEDURAL MEDICINE • AUTHENTIC CARE

Patient Responsibility for Fees Policy

Thank you for choosing M. Chavez, MD, SC (the "Clinic")! We believe that good quality care begins with great communication and transparency. We have created this policy to help you (and your family) understand your financial responsibility when it comes to payment of our fees. Please understand that our contract for services is with you, and it is our policy that you are responsible for our fees regardless of insurance coverage.

All payment is expected at the time of service. Payment at the time services are rendered is expected unless other arrangements have been made in advance of your appointment. This includes applicable coinsurance and copayments for participating insurance companies. The Clinic accepts cash, personal checks (in-state only), VISA, and MasterCard. **There is a $25.00 service charge for returned checks.**

Unpaid balances. You will receive statements and reminders or calls for all balances pending and owed by you. You agree to receive these communications. No future well/prevention visits will be scheduled if your open balance is 90 days or more overdue. We realize that financial difficulty is a reality. In such circumstances, we can assist you with a payment plan that meets both our needs. You also have the option of seeking care or immunization through an FQHC (federally qualified health center) or health bureau.

Credit / Debit card authorizations. All patients are asked to supply the Clinic with a valid credit or debit card prior to the first visit to ensure timely medical care, prevent payment delays and non-payment by insurance. By providing us with a credit card, you acknowledge and agree that M. Chavez, MD, SC (the Clinic) has your authorization and permission to apply any charges deemed to be your responsibility to the credit card on file without obtaining any further or continued authorization. Please complete the requested information at the end of this form.

Insurance. We bill participating insurance companies as a courtesy to you. Your role is to pay your deductible, copayments and other outstanding balances at the time of service unless arrangements are made in advance of your appointment. If we have not received payment from your insurance company within 45 days of the date of service, you will be expected to pay the balance in full. Your responsibilities include assurance that all charges are paid whether by you or by your insurance carrier. We do not bill secondary insurance companies. Your time-of-service receipt includes all information necessary for submitting claims to your insurance company.

Refunds. Patient/guarantor credits in amounts $20.00 or less will be retained on account to be credited toward future balances unless a written request for refund is received. Amounts greater than $20.00 will automatically be refunded to the patient/guarantor.

Managed Care / Referrals. If you are enrolled in a managed care insurance plan (i.e. HMO) and request to see a specialist, please come by the office for a referral prior to your visit with the specialist. Retroactive referrals are discouraged because they offer no guarantee of payment and may result to an added cost to you.

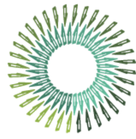
Missed appointments / late cancellations. Appointment cancellations are requested 24 hours or more prior to your scheduled appointment. Missed appointments (AKA no shows) and late cancellations represent a cost to us and to other patients who could have been seen during the time set aside for you. **Our fee for missed or late cancellations is $75.00 for a medical visit and $100.00 for a procedural visit**. Excessive abuse (3 or more late cancellations in a 6 month period) of our cancellation policy will result in a warning letter and may result in discharge from the practice.

After hours / Emergency fees. There may be a charge in conjunction with any office visit or service performed after posted office hours. A bill will be submitted to your insurance company for these services. Any services not covered by insurance will be your responsibility.

Please Contact us with your questions. For questions regarding your account please call Kristine (815-524-5229) at our billing office Monday through Friday between 9:00 am and 4:30 pm. You may also email your billing questions to Mireya@mchavezmd.com. For all other questions, please call the Clinic at 773-227-3303 or email us at info@mchavezmd.com Thank you.

I have read and understand the Clinic's Patient Responsibility for Fees Policy. I agree to assign insurance benefits to the Clinic whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I will also be responsible for the fee charged by the collection agency for costs of collections. Furthermore, I understand that I am responsible for complying with all policies and fees as described herein. I understand that the Clinic reserves the right to change any fees and or policies without prior notification.

______________________________	______________________________	__________
Patient's Name	Signature of Guarantor/Responsible Party	Date



Consent for Telehealth Services

1. _____I understand that the laws that protect privacy and the confidentiality of medical information also apply to telehealth, and that no information obtained in the use of telehealth, which identifies me, will be disclosed to researchers or other entities without my consent.

2. _____I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.

3. ______I understand that I have the right to inspect all information obtained and recorded in during a telehealth interaction and may receive copies of this information for a reasonable fee.

4. ______I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My provider has explained the alternatives to my satisfaction.

5. ______I understand that telehealth may involve electronic communication of my personal medical information to other medical practitioners who may be in other areas, including out of state.

6. ______I understand that it is my duty to inform my provider of electronic interactions regarding my care that I may have with other healthcare providers. I also understand that there are benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.

7. ______I understand that telehealth and all its services may not be covered by my insurance and that it is up to me to determine if this is the case.

Patient consent to the use of telehealth

I have read and understand the information provided above regarding telehealth, have discussed it with my physician or such assistants as may be designated, and all my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth in my medical care.

______________________________________ ________________

Patient Signature Date

M.Chávez MD, SC
PROCEDURAL MEDICINE • AUTHENTIC CARE

1509 N. Western Ave, Unit-A
Chicago, IL 60622
T: (773) 227-3303
F: (312) 575-3507
www.mchavezmd.com

Authorization for Release of Medical Records

Patient Name: ____ Date of Birth: _____________________

Phone: ____

Address: __________________________________ City/State/Zip: ____________________________

I authorize the following healthcare facility to disclose/release the information indicated below:

Facility Name: ___________________________________ Facility Phone: ________________________

Facility Fax: ____

Facility Address: _________________________________ City/State/Zip: _________________________

- ☐ All records
- ☐ Laboratory and pathology records
- ☐ X-Ray/radiology records
- ☐ Billing records
- ☐ Abstract/summary
- ☐ Pharmacy/prescription records
- ☐ Other (please describe specifically): ______________________________

Note: If these records contain information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.

The records are for services provided on the following date(s): ___________________________________

Please send the records listed above to:
M. Chávez, MD, SC
1509 N Western Ave. Unit – A; Chicago, IL 60622
T: (773) 227-3303
F: (773) 897-5848
The information may be used/disclosed for the following purposes:

- ☐ At my request
- ☐ For my healthcare
- ☐ For payment/insurance
- ☐ For employment purposes
- ☐ Other: ________________________ ______________________________

This authorization shall expire no later than ___ / ____ / ____ or upon the following event ___________ (whichever is sooner), and will expire one year from date of signature.

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign it will not affect my ability to receive treatment, receive payment, or eligibility for benefits unless allowed by law. By signing below, I represent and warrant that I have the authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

______________________________________	______________________________
Signature of Patient (Or Patient's Personal representative)	Date
______________________________________	______________________________
Printed Name of Patient Representative	Representative's authority to sign for patient

You have the right to revoke this authorization, except to the consent the custodian of the records has relied on it, by sending your written request to 1509 N. Western Ave, Unit - A, Chicago, IL 60622
A copy of the signed authorization must be given to the individual.

Patient Health Questionnaire and General Anxiety Disorder
(PHQ-9 and GAD-7)

Date_______________ Patient Name:________________________________ Date of Birth: ______________

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.

PHQ-9	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): ______________

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.

GAD-7	**Not at all sure**	**Several days**	**Over half the days**	**Nearly every day**
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): ______________

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

UHS Rev 4/2020

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc.
No permission required to reproduce, translate, display or distribute, 1999.

M.Chávez MD, SC
PROCEDURAL MEDICINE • AUTHENTIC CARE

Notice of Privacy Practices Acknowledgement

I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Obtain payment from third-party payers.
- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers I understand that, under the Health Insurance Potability & Accountability Act of 1996 (“HIPAA"), who may be involved in that treatment directly and indirectly.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. The notice takes effect 4/2/2013 and remains in effect until we amend it.

We reserve the right to change our privacy practices and the terms of this notice, provided such changes are permitted by applicable law. We reserve the right to make any and all changes in our privacy practices for all health information that we maintain, create or receive. Any changes to our policy will be made immediately online and will be available upon request.

Persons Involved in Care

We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, knowledge of your location, your general condition or your death. We will disclose health information (which we deem directly relevant and based on our professional judgment) to the person’s involvement in your healthcare for any emergency circumstance prior to disclosure of your incapacity. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Required by Law: We may use or disclose your health information when required to do so legally or when subpoenaed by worker compensation programs, public health agencies, or law enforcement agencies.

National Security

We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may authorize disclosure of your health records to federal officials for lawful intelligence, counterintelligence, and other national security activities. We may also

under certain circumstances, disclose information to correctional institutions or law enforcement officials who have lawful custody of protected health information of inmates or patients.

Patient Rights

Access: You have the right to look at or get copies of your health information, with limited exceptions. Your medical records are made available to you electronically via Patient Fusion, the patient portal of our clinic's EMR program Practice Fusion (https://www.patientfusion.com). You will be issued a Patient Fusion log-in at the time of your first visit, if we receive a valid email address for you or your caretaker. On the patient portal, you will have free access to your patient progress notes within 24 hours of your visit. Faxed copies of these notes must be made in writing and will be sent within a week and include a fee for the service. Charges are computed per Public Act 92-228 Sept. 1, 2001. You may obtain a medical record request form by contacting our office.

Disclosure Accounting

You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities for the last 7 years, but not before April 2, 2013. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. You must make a request in writing.

Restriction

You have the right to request (in writing) that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement except in any situation we deem an emergency.

Amendment

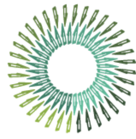
You have the right to request that we amend your health information. Your written request should explain why the information should be amended. Under certain circumstances, we may deny your request at which time, you may appeal.

Electronic Notice

You are entitled to receive this or any electronic notice from our office in written form at no charge.

If you are concerned that we may have violated your privacy rights or if you disagree with any decision, we have made regarding access to your health information, you may file a written complaint by contacting us directly. You may also submit a written complaint to the U. S. Department of Health and Human Services, Office of Civil Rights. To have us communicate with you by alternative means or at alternative locations or for more information regarding updates to our policy, please contact us directly.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file complaint with us or with the U.S. Department of Health and Human Services.



M.Chávez MD, SC

PROCEDURAL MEDICINE • AUTHENTIC CARE

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

☐ **I agree** ______________________________
Patient Signature

______________________________ ______________
Patient Name Date

Contact: **Mireya Maldonado, Office Manager**
mireya@mchavezmd.com
773-227-3303

1509 N. Western Ave. Unit A, Chicago, IL 60622 | Phone: (773) 227-3303 | Fax: (773) 897-5848
www.mchavezmd.com | info@mchavezmd.com