Angela Intili, M.D., Ltd.

Patient Signature Form

(Please initial at all the corresponding *)

*_____ Privacy Notice

I hereby acknowledge that I have received the Notice of Privacy Practices from Angela Intili, M.D. LTD.

_____ *In lieu of the patient signature, I _____, a staff member of Angela Intili, M.D. LTD, state that this patient has been given our current Notice of Privacy Practices.*

*_____ Authorization to Discuss My Account

I hereby give my authorization to the staff of Angel Intili, M.D. to discuss my account and/or medical information with the person whose name appears *printed* on the line below. If I do not wish to designate anyone, I will check the appropriate box below.

☐ Designated person: _____
(name) (date of birth) (relationship to patient)

☐ I do not want my account or medical information discussed with anyone but me.

*_____ Consent to Treat:

I hereby authorize and consent to the performance of examinations, diagnostic procedures, and treatments which my physician and I agree are necessary. I understand that no guarantee has been made as to the results of the care, treatment, and/or medications given to me. This consent shall remain in effect until I choose to revoke it in writing.

*_____ Release of Information and Assignment of Benefits:

I understand that I am responsible for any fees for services rendered for myself and/or for my children (if applicable). I hereby authorize Angela Intili, M.D. LTD to furnish information to my insurance carrier concerning all conditions including those that may reference drug abuse, alcohol abuse, or mental illness. I hereby assign to Angela Intili, M.D. LTD payments made by my insurance carrier until such time as I revoke this in writing.

*_____ Patient Financial Responsibility

I understand that Angela Intili, M.D. LTD will, as a courtesy to me, submit the charges for my visit to my primary and secondary insurance carriers. If there is any question regarding coverage, benefits, or payment for services provided, I understand that it is my responsibility to resolve this. I also understand that I am financially responsible for any covered or non-covered services which are not paid by my primary or secondary insurance and that any unpaid charges over 60 days old will become my responsibility, with payment due from me plus processing costs. In the event my account is placed with an agency for collection purposes, I understand that I am responsible for all collection agency fees (up to 35% of the balance placed for collection). In addition, I will be responsible for all court costs, filing fees, and attorney fees should this account require litigation.

Additional charges will apply for the following:

Failing to cancel your appointment at least 24 hours ahead --- $30.00
Failing to cancel your surgery at least five days prior to surgery date --- $75.00
None sufficient bank funds (check bounces) --- $25.00
FMLA, insurance forms, work forms, school forms, etc. --- $50.00
Returned mail (Insufficient address) --- cost of postage due

My signature in the box above indicates my knowledge of and agreement with all of the above. Further, I understand and agree that my consents/assignments remain in effect until I choose to revoke them in writing.

******* *Please complete other side* *******

*_____ Practice Policies

My signature above indicates that I have been given a copy of Dr. Intili's Practice Policies. I understand that the office will follow these policies with regard to my care and the processing of charges to my insurance company. I also understand that if I have any questions, the staff will be happy to answer them for me.

My signature in the box below indicates that I have read and understand the information on the front side of this paper.

(Signature of patient or authorized representative)	(Printed name)	(Date)
(If signed above by representative, relationship of signer to patient)		(Name of patient if different from above)

********** ***For Medicare Patients Only*** **********

Medicare Assignment of Benefits

I request that payment of authorized Medicare benefits be made on my behalf to Angela Intili, M.D. LTD for services provided to me by the above physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. This assignment of benefits is to remain in effect until I choose to revoke it in writing.

(Beneficiary/Patient signature) (Date)

Medi-Gap Assignment of Benefits (Medigap = Secondary Insurance)

I request that payment of authorized Medi-Gap benefits be made on my behalf to Angela Intili, M.D. LTD for services provided to me by the above physicians. I authorize any holder of medical information about me to release to my Medi-Gap insurer any information needed to determine these benefits or the benefits payable for related services. This assignment of benefits is to remain in effect until I choose to revoke it in writing.

(Beneficiary/Patient signature) (Date)

Angela Intili, M.D., Ltd.

Date: _____

PATIENT INFORMATION

Name: _____ Birth date: _____
First MI Last

Soc. Sec. #: _____ Marital Status: *Single* *Married* *Widowed* *Divorced*

Race: *American Indian* *Asian* *African American* *Caucasian* *Hispanic/Latino* *Other*_____ *Choose not to disclose*

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Referring Dr: _____ Phone: _____ Primary Care Dr.: _____ Phone: _____

Occupation: _____ Employer: _____ Work Phone: (___) _____

Address: _____ City: _____ State: _____ Zip: _____

How did you find us? : _____

EMERGENCY CONTACT

Name: _____ Relation: _____

Home Phone: _____ Cell Phone: _____

PHARMACY

Pharmacy Name: _____ Pharmacy Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

INSURANCE INFORMATION

Please give your insurance cards to the receptionist to copy for your chart and complete the following information:

PRIMARY INSURANCE INFORMATION

Name of Insurance Company: _____ Insurance Effective Date: _____

Address to mail claims: _____ City State Zip: _____

Customer Service Phone: _____ Preauthorization Phone: _____

Policy Holder Name: _____ Policy Holder Date of Birth: _____

Relationship of Policy Holder to Patient: _____ Policy holder employer: _____

SECONDARY INSURANCE INFORMATION

Name of Insurance Company: _____ Insurance Effective Date: _____

Address to mail claims: _____ City State Zip: _____

Customer Service Phone: _____ Preauthorization Phone: _____

Policy Holder Name: _____ Policy Holder Date of Birth: _____

Relationship of Policy Holder to Patient: _____ Policy holder employer: _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____
name of insurance company

and assign directly to Dr. Angela Intili all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship Date

***** Please complete reverse side *****

Angela Intili, M.D., Ltd.

Date: _____

HEALTH HISTORY

(CONFIDENTIAL)

Reason for today's visit: _____

_____

Patient Health History

Have you had any labs, mammogram, ultrasounds, or other imaging recently? *Yes* *No*

If so, what, when and where? _____

Allergies (*Drug/Medications*):

_____

_____

_____

Allergies (*Other – seasonal, food, etc*):

_____

_____

_____

Gynecology History

Date of Last Period: _____ Previous Menstrual Period(s): _____ _____

Date of Last Pap: _____ Results: _____

How often do you get your periods? *28-30 days* *less frequent* _____ *more frequent* _____

How long do your periods usually last? _____

How heavy are your periods? *Light* *Moderate* *Heavy* *Extremely Heavy*

Do you experience bad cramping? *Yes* *No* Do you experience PMS symptoms? *Yes* *No*

Do you have bleeding between periods? *Yes* *No* Do you have bleeding after intercourse? *Yes* *No*

Are you experiencing any breast problems (lump, pain, discharge, etc)? _____

Family History

☐ Breast Cancer _____ (relationship)
☐ Uterine Cancer _____ (relationship)
☐ Ovarian Cancer _____ (relationship)
☐ Other Cancer _____ _____ (relationship)

☐ Diabetes _____ (relationship)
☐ Heart Disease _____ (relationship)
☐ High Blood Pressure _____ (relationship)
☐ Stroke _____ (relationship)

☐ Thyroid Disorder _____ (relationship)
☐ Mental Illness _____ (relationship)
☐ Other _____ _____ (relationship)

Habits

Smoker? *Yes* *No* Drink alcohol? *Yes* *No* Other drugs? *Yes (if so, what* _____*)* *No*

Medical History

☐ Asthma ☐ Lung disease ☐ Breast Cancer ☐ Uterine Cancer ☐ Ovarian Cancer
☐ Other Cancer _____ ☐ HIV/AIDS ☐ Heart Disease ☐ High Blood Pressure
☐ High Cholesterol ☐ Diabetes ☐ Mental illness ☐ Kidney Disease
☐ Thyroid Disorder ☐ Liver Disease ☐ Other _____

Pregnancy History

TOTAL Pregnancies: _____ Full Term: _____ Premature: _____ Ectopic: _____ Living: _____
Abortions Induced (termination): _____ Abortions Spontaneous (miscarriage): _____ Multiple Births: _____

Surgical History

Please list all past surgeries, including dates: _____

_____

Please list all current medications:

_____

_____

_____

Angela Intili, M.D., LTD

NOTICE OF PRIVACY PRACTICES

This notice takes effect on February 6, 2013 and remains in effect until we replace it.

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

OUR PLEDGE REGARDING HEALTH INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive from us because we need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. It will also describe your rights and certain duties we have regarding the use and disclosure of medical information.

1. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we are permitted to use and disclose medical information. Not every use or disclosure is listed, but each use or disclosure falls into one of these categories. Any use or disclose of your medical information for any purpose not listed below requires a written consent from you, which you may revoke at any time in writing to us.

For Treatment:

We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are involved in your care. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process.

For Payment:

We may use and disclose health information about you so that the treatment and services you receive from us may be billed to and payment collected from you, an insurance company, or a third party. For example, we may need to give your insurance company information about your office visit so your insurance plan will pay us or reimburse you for the visit.

For Health Care Operations:

The use and disclosure of health care information may be necessary to run our practice and make sure that all of our patients receive quality care. For example, we may use health information to evaluate the performance of our staff in caring for you. We may also use information for accreditation, certificates, licenses, and credentials we need to serve you. We may use health care information in providing appointment reminders to our patients.

NOTICE OF PRIVACY PRACTICES

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Additional Uses and Disclosures:

In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes:

- As Required By Law
- Disaster Relief
- Workers' Compensation
- Public Health Risks
- Health Oversight Activities
- To Avert a Serious Threat to Health or Safety
- Specialized Government Functions (Military and Veterans)
- Court Orders, Judicial & Administrative Proceedings
- Victims of Abuse, Neglect, or Domestic Violence
- Law Enforcement

2. YOUR INDIVIDUAL RIGHTS

You have a right to inspect and copy your medical information.

You must make your request in writing to the attention of Medical Records and allow two weeks for processing. We will request that you complete our release form and pay a fee of $10.00 to cover our cost of copying the records.

You have the right to amend your information.

If you feel that your health information is incorrect or incomplete, you may request an amendment in writing to the privacy officer listed below. You must provide a reason that supports your request.

You have the right to an accounting of disclosures

You may request a listing of disclosures of your health information made for purposes other than treatment, payment, or operations. Your request must be submitted per directions below.

You have the right to request restrictions on information released

For example, you could ask that we not disclose information to your spouse about a surgery you had. We are not required to agree to your request if we feel it will have a negative impact on your care. If we do agree, we will abide by our agreement. Your request must be submitted per directions below.

You have the right to request confidential communications

You may request that we communicate with you about health matters in a certain way or at a certain location. For example, you may ask that we only contact you at work. Your request must be submitted per directions below.

NOTE: All requests for information or other specific requests must be in writing and directed to Carolyn Longi, the Privacy Officer at the address listed in #4 below. Please allow 14 days for a response.

NOTICE OF PRIVACY PRACTICES

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3. OUR LEGAL DUTY

We are legally required to: Keep your medical information private. Provide you with this notice regarding our legal duties, privacy practices, and your rights regarding your medical information. Follow the terms of this notice that is now in effect

We have the right to: Change our privacy practices and the terms of this notice at any time, provided the changes are permitted by law. Make the changes effective for all medical information that we keep, including information previously created or received before the change.

We will: Make any changes in our privacy practices available upon request before we implement them.

4. QUESTIONS AND COMPLAINTS

Please address questions or complaints to Practice Manager, c/o Angela Intili, MD; 1415 Essington Road; Joliet, IL 60435; phone 815-729-2084.

If you think that we may have violated your privacy rights, contact the person named above. You may also submit a written complaint the US Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

Angela Intili, M.D., Ltd.
1415 Essington Rd
Joliet, IL 60435
815-729-2084 Fax 815-729-2304

Practice Policies

We welcome you to our practice! In order to better serve you, we would like to outline our practice policies. The information that follows is intended to answer any questions that you may have and to help you to be well informed. Please remember, should you have any additional questions, please let us know and one of our staff members will be happy to assist.

1. **Cancellations**: If you must cancel your appointment, we would appreciate your doing this at least 24 hours in advance so that another patient may use your appointment time. Please note that your account will be charged a $25.00 no-show, no-cancellation fee.

2. **New Patients:** We require our new patients to bring the following to their first appointment:
   a. A co-payment if your insurance requires one. We accept cash, checks, and credit cards and require you to pay this amount upon registration and check-in.
   b. Your insurance card(s) & proof of identification (i.e. drivers license)
   c. A complete list of your medications including dosages
   d. Any questions you may have for the doctor

3. **Insurance Plans:** Since payment of charges for services provided to you is ultimately your responsibility, we encourage you to call your insurance company to verify your coverage for visits to our office. We also encourage you to confirm that Dr. Intili is a provider in your insurance network.

4. **Laboratory Charges**: We send specimens to Quest Laboratory for analysis. If your insurance requires that we use a different laboratory, we must know this at the time of your registration and you must provide us with the proper implements/documents for processing. We will then require you, the patient, to take the specimen to your laboratory of choice for processing. We must inform you that it is your responsibility to ensure that we submit specimens to your correct laboratory.

5. **Account Balances:** As a courtesy to you, we will submit the charges for your visit to your primary and if applicable, secondary insurance carriers. We will send a statement to you for your portion of these charges after your insurance has paid. Your balance is due and payable upon receipt of your statement.
   Any balance over 60 days old will be considered delinquent and subject to our collection process.

6. **Prescription Refills**: We encourage you to call your pharmacy and have the pharmacist fax a request for a refill to us during normal business hours. Our fax number is 815-729-2304. Please allow 24 – 48 hours for processing of your refill.

7. **Completion of Forms/FMLA:** We are happy to assist you with completion of forms for your insurance carrier or disability insurance. ***We request that you complete your personal information such as, name and address, etc. PRIOR to submitting them to our staff*** for completion. Our **fee for these forms is $30**.
   Please allow 7-10 days for the processing.

8. **Medical Records:** If you need copies of your medical records, we request that you complete our Medical Release Request Form which we can fax to you upon request, or you can print it off of our web-site at www.angelaintili.com We do charge for our cost of preparing copies of your records as allowed by Illinois law. This charge varies with the number of pages we are required to process. Please allow 5 business days for the duplicating/processing of medical records.