PATIENT REGISTRATION FORM

Date: ______________

Primary Care Provider ____________________________

1. Patient Information:

Email:

Last Name	First Name	Middle Initial

Street Address	Apt. #	City	State	Zip Code

Home Phone #	Social Security #	DOB - Month Date Year
	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	

Patient's Occupation	Patient's Employer	Patient's Work #

Patient's Employer Address	Patient's Working Hours

Patient's Maritial Status	Spouse Name	Maiden Name	Sex
S M D W			**M F**

2. Insured/Responsible Party Information: If the patient and the insured are the same, please skip #2 and complete numbers 3, and 4.

Last Name	First Name	Middle Initial

Street Address	Apt. #	City	State	Zip Code

Home Phone #	Social Security #	DOB - Month Date Year

Insured's Occupation	Insured's Employer	Insured's Work #

Insured's Employer Address	Insured's Working Hours

3. Emergency Contact Information:

Last Name	First Name	Middle Initial

Street Address	Apt. #	City	State	Zip Code

Home Phone #	Work Phone#	Working Hours

4. Insurance Information: Attach copies of Insurance Card, both sides.

Name of Primary Insurance	Group # (If DPA, please include case ID number)	(Identification #:)
Name of Secondary Insurance	Group # (If DPA, please include case ID number)	(Identification #:)

WHITE - Medical Record **YELLOW** - Billing Service

Integrative Family Practice
Malgorzata Sypien, M.D.
Blending Traditional & Alternative Solutions for Better Health
5012 W. Lawrence Ave.
Chicago, IL 60630
T (773) 205-2555
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www.familydoctorchicago.com

HIPAA Patient Consent Form

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Integrative Family Practice to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

I have the right to review the Notice of Privacy Practices prior to signing this consent. Integrative Family Practice reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Integrative Family Practice.

With this consent, Integrative Family Practice may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Integrative Family Practice may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, Integrative Family Practice may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Integrative Family Practice restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Integrative Family Practice to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Integrative Family Practice may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Print Patient's Name or Legal Guardian Date

RELEASE OF PATIENT INFORMATION FOR PAYMENT, REVIEW AND DISCHARGE PLANNING

1. GENERAL RELEASE:

I hereby authorize **Malgorzata Sypien, M.D.** and any physician or other health care provider who may treat me to release ANY AND ALL INFORMATION CONTAINED IN MY MEDICAL RECORD to:

a) Entitles involved in billing and collection for **Malgorzata Sypien, M.D.** and third party payers responsible for payment of patient charges (including but not limited to insurance companies, health benefit plans, employers involved in approval of benefit claims, government agencies or intermediaries representing any of the above);
b) Any organization or government agency authorized to review quality, utilization or cost of care, or any person or organization involved in discharge planning.

FOR THE PURPOSE(S) OF:

a) Billing and security payment for hospital, physician and other services related to my diagnosis and treatment;
b) Review of quality, utilization and cost of care and discharge planning;

2. SPECIFIC RELEASE FOR MENTAL HEALTH, DRUG OR ALCOHOL ABUSE AND HIV INFO.:

I hereby specifically authorize Malgorzata Sypien, M.D. and any physician or other health care provider who may treat me for mental health, drug or alcohol abuse or HIV and related diseases to release any and all information contained in my medical records to the persons and organizations and for the purposes stated in paragraph 1 above. I agree that specific consent contained in this paragraph shall apply even if I am diagnosed and/or treated for one of the above conditions for the first time during this visit/hospital stay.

I understand that I have the right to inspect information to be disclosed. Please initial the diagnosis(es)/condition(s) for which you do not consent to the release of medical information if any.

HIV_____ Mental Health_____ Drug and Alcohol Abuse_____

I understand that if I do not consent to release of record, I will be fully responsible for payment of all charges for diagnosis and treatment received.

3. DURATION AND REVOCATION:

This consent to release information expires one year after the date of the signature below or at such time a payment and review have been made, whichever is sooner. Consent for outpatient service expires on revocation. I have the right to revoke this consent at any time giving written notice to the Director of Medical Record(with no effect on prior disclosures).

I assert I have read and understand this form, that I freely and voluntarily accept its terms, and that I am the patient or am authorized to sign on the patients behalf. (If the patient's representative is signing for the patient, all references on this form to "I" or "my" shall refer to "the patient" as applicable).

_____

Patient's signature and Date

INTEGRATIVE FAMILY PRACTICE
Malgorzata Sypien, M.D.
5012 W. Lawrence Ave.
Chicago, IL 60630
Phone: 773-205-2555
Fax: 773-205-4439

1. It's a full responsibility of each patient to check his/her insurance coverage for each visit, consultation and test performed or ordered.

2. Please be aware that your insurance company may not cover well visits and lab tests. If not, you will be asked to pay for them.

1. Pacjent jest zobawiazany do sprawdzenia czy jego/jej aktualne ubezpieczenie pokrywa koszty wizyty, konsultacji, zleconych testow i badan krwi przed kazda wizyta.

2. Niniejszym informujemy, ze nie kazde ubezpieczenie pokrywa koszty wizyty prewencyjnej (profilaktycznej). Jesli panstwa ubezpieczenie nie pokrywa tego rodzaju wizyty, rachunek za wizyte i wykonane testy pokrywa pacjent.

SIGNATURE AND DATE