

1302 Franklin Ave., Suite 2800, Normal, IL 61761 • 309-454-3456

Thank you for scheduling an appointment with our office. It is our pleasure to welcome you to Heart of Illinois OB-GYN in advance of your first visit.

In this packet you will find some patient information that will help familiarize you with the practice and how we operate. If you have any questions after reading the material, please feel free to phone us and we will be address them prior to your visit. We have also included our Patient Information Form and Acknowledgment of Receipt of Notice of Privacy Practices Form. After reviewing, please complete these forms and bring them with you to your appointment. In addition, please bring your insurance card and a photo I.D., so that we may have a copy for our records. We would like to remind you, that understanding your insurance coverage is the patient's responsibility. We recommend that you call your insurance to be aware of how they cover office visits and what hospital they will cover. Being informed of these preferences ensures you will have the optimum payment of services and no surprises when billed.

We invite you to acquaint yourself with our office philosophy and be introduced to the staff by viewing all areas of our website, before your scheduled appointment time.

We appreciate you selecting our office for your medical care. Our entire staff will work hard to serve your needs.

Serving Christ through healthcare,

Dr. Rachel Dalton & Dr. Jared Zotz



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FINANCIAL POLICY

It is our hope that you will understand that our office financial and billing policies are necessary to maintain vital health care services to our patients and community.

Our practice is committed to providing the best treatment possible for our patients and we charge what is *usual and customary* in this area. You are responsible for payment in full, regardless of any insurance company's arbitrary determination of usual and customary rates.

INSURANCE AND BENEFITS

Remember that insurance is a contract between you and your insurance company, and it is your responsibility to understand the basic coverage of that contract. Please check with your insurance company to verify if a referral is required prior to your visit and what their preferred hospital choice is.

If you are covered by **two separate insurance policies,** it is your responsibility to contact both to set up Coordination of Benefits (COB), prior to your appointment. Inform Check-In personnel as to which policy is primary and which is secondary to ensure that your insurance is billed properly.

PAYMENTS

- Co-payments will be collected on the day of your appointment, as you check in. All insurance companies require that the physician collect all co-pays from the patient.
- According to the American Medical Association CPT coding & guidelines, our office charges for treatment & diagnosing over the phone from our doctor, nurse practitioners & nurses.

OFFICE PAYMENTS

We request that all office visit charges and office procedures be paid at the time of service, unless you are covered by an insurance plan that we are currently enrolled in.

WE ACCEPT CASH, CHECKS, DISCOVER CARD, VISA & MASTER CARD CREDIT CARDS.

PAYMENT PLANS

In circumstances where a claim is pending, or no insurance coverage exists, a payment plan may be initiated through our billing department. We will be pleased to cooperate with you in establishing a payment plan, <u>prior</u> to services provided.

CANCELLATIONS/NO SHOW

Our office is looking forward to participating in your healthcare. We ask that if you are unable to keep your scheduled appointment, please make every effort to contact our office at least 24 hours prior to the appointment date. In the event that you miss 3 or more appointments without cancelling, the provider may decide to discontinue your care with this office.

Patient Name	Date of Birth
Patient Signature	Date



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PATIENT INFORMA		SSN#		BIRTHDATE	LAI	NGUAGE	SEX (c	circle)				
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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, and any finance charges incurred on all balances over 60 days and any collection costs such as collection fees, attorney fees, and court room costs. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions and any collection processes.



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Acknowledgment of Receipt of Notice of Privacy Practices

I,	(print name), have received a copy of this office's
updated No	tice of Privacy Practices.
Signature o	f patient or parent/legal guardian/legally responsible person
Date of Birt	<u></u> h
Description	of relationship to the patient
	Date
	For Office Use Only
We attempte obtained bed	ed to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be cause:
	Individual/Representative refused to sign the form
	An emergency situation prevented us from obtaining acknowledgement Other (Please Specify)



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Patient Authorization for Use & Disclosure of Protected Health Information and Notification of Test Results

I	give my permission to release my
medical information and lab results to	give my permission to release my the following persons only:
Name	
Do you want our office to notify you if Phone number to contact you with you Would you like messages to be left wit	ur results: th results? Yes No
Primary Care Physician	
, , , , , , , , , , , , , , , , , , , ,	ant and your lab results are normal, results will be seel free to call the office if you desire to discuss your ment.
	ill contact you with all abnormal results. Please been notified of your test results within 14 days.
Print patient name:Signature of patient:Today's date:	Date of Birth:

This information will remain in effect, until revoked in writing, by patient.

Revised 9.20.2018/1.9.2019/4.8.2019/7.11.19/1.27.2020/NPP



Heart of Illinois Obstetrics & Gynecology 1302 Franklin Avenue, Suite 2800, Normal, IL 61761 Phone: 309-454-3456 Fax 309-454-6977

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Reviewed on _____by__ Clinical Forms 8.2018/Revised 9.2018/Revised 10.2018/4.16.2019/7.11.2019/9.3.2019