Villa Medical Arts

New Patient Forms

New patients,

To expedite your check-in process, please print and complete the following pages.

If you have access to a fax machine, please fax them along with a copy of your driver's license and insurance card (front and back) to:

630-832-9049

If you do not have access to a fax machine but are able to complete the documents, simply bring them with you on your appointment along with proof of identification and insurance card.

NOTE: If your insurance carrier requires a referral prior to the visit, please bring it along as well.

Please feel free to contact us if you have any questions.

Thank you.

Villa Medical Arts

Financial Policy

Thank you for selecting Villa Medical Arts for your Health Care. In order to prevent any misunderstanding concerning the responsibility regarding payment for medical/surgical care and/or any laboratory fees, the following information is provided:

HMO/PPO/Other Insurance Coverage:

If you have insurance through a company we have contracted with, we will require a copy of your insurance card and driver's license. **All co-payments are due prior to seeing the physician. You will be responsible for any coinsurance and deductibles and will be billed for them.** If your insurance carrier requires a referral from your primary care physician, this must be presented at the time of service. Failure to provide all necessary information may require you to pay in full on the date of the visit. It is your responsibility to keep track of referral expiration dates and the number of visits given by your primary care physician. You will be responsible for any services denied by your insurance carrier as not medically necessary and/or not covered.

Medicare:

Our physicians are participating Medicare providers and accept Medicare assignment, which is the ALLOWABLE charge approved by Medicare. Medicare will pay 80% of the allowable charges after you pay your annual deductible. You are responsible for any amount applied to your deductible and the 20% co-insurance. If you have a secondary insurance, as a courtesy we will submit to the particular carrier any remaining balance. You will also be responsible for any services denied by your insurance carrier as not medically necessary and/or not covered.

Laboratory:

Depending on your insurance carrier's policy, you may be required to pay a separate co-payment for any specimen taken during your visit.

Self-Pay Patients:

For patient's with no insurance, the guarantor is responsible for the bill at the time of service.

Payments:

Payments can be made by cash, check, Visa or MasterCard

Returned Check:

A charge of $15.00 will be added for all returned checks.

Collection Accounts:

If an account has gone to collections, the patient may make an appointment, however, payment in full at the time of service is required.

Certified Letter Sent:

If the patient has received a certified letter from us, they are not to be seen, no appointment should be made.

Medical History

*Date:*_____

Villa Medical Arts
10 E. Central Blvd.
Villa Park, Il 60181

Name _____ Age___ Birth date_____ Sex M F

Address_____ Home phone_____
_____ Work phone_____
_____ Emergency contact_____

Occupation_____ Phone_____
Employer_____
☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Married, spouse's name_____
Children's names and ages_____

Allergies to Medications, Xray dyes, Latex, or other ☐ **No** ☐ **Yes**
if yes, please list name(s) of medicines(s) and types(s) of reaction:

_____
_____
_____
_____

Past Medical History and Review of Systems
Please circle if **you** have had problems with or are currently complaining about any of the following:

1. High blood pressure
2. Diabetes
3. Cancer
4. Heart disease
5. Chest pain/tightness
6. Shortness of breath
7. Swollen ankles
8. Palpitations
9. Lightheadedness
10. Frequent urination
11. Rheumatic fever
12. Asthma
13. Bronchitis
14. Pneumonia
15. Persistent cough
16. TB
17. Hay fever
18. Abdominal discomfort
19. Indigestion
20. Nausea
21. Constipation
22. Diarrhea
23. Blood in stool
24. Ulcers
25. Change in bowel habits
26. Unexplained weight gain/loss
27. Hemorrhoids
28. Gall bladder disease
29. Colitis
30. Hepatitis or jaundice
31. Thyroid disease
32. Radiation to head or neck
33. Headache
34. Kidney diseases
35. Kidney stones
36. Arthritis
37. Low back problems
38. Skin diseases
39. Blood disorders
40. Venereal disease
41. Anxiety
42. Depression
43. Anemia
44. Hernia
45. AIDS/AIDS related illness

Do you smoke? Yes No Packs/day_____
Alcohol? Yes No Drinks/week _____
Do you use illicit drugs Yes No **In the past**? Yes No
Do you have an Advanced Directive or Living Will? Yes No
When was your last tetanus shot?_____
When was your last complete physical? _____

Family History (Please circle)

1. Coronary artery disease
2. Kidney disease
3. Gastrointestinal disease
4. Diabetes
5. Liver disease
6. Neurological Disease
7. Stroke
8. Lung Disease
9. Vein or artery disease
10. Cancer

Gynecologic and Obstetric History – WOMEN

Date of last PAP test: _____

Age at onset of periods:_____ Frequency: _____ Length of period: _____
Pregnancies:_____ Births:_____ Miscarriages: _____

Prolonged or abnormal bleeding:	☐ No	☐ Yes (Please describe)_____
Leakage of urine:	☐ No	☐ Yes (Please describe)_____
Pelvic pain:	☐ No	☐ Yes (Please describe)_____
Abnormal discharge:	☐ No	☐ Yes (Please describe)_____
History of abnormal Pap Smear:	☐ No	☐ Yes (Please describe)_____

Villa Medical Arts 10 E. Central Blvd. Villa Park, IL 60181

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient Name_____ Age_____Birthday _____ Sex_____

Address_____ APT. # _____

CITY/STATE _____ ZIP _____

SOCIAL SECURITY # _____-_____-_____HOME PHONE _____CELL_____

MARITAL STATUS _____SPOUSE'S NAME _____ STUDENT-- FULL TIME_____ PART TIME _____

EMPLOYER NAME_____WORK PHONE_____

INJURY-WORK RELATED. _____ AUTO ACCIDENT? _____ OTHER (SPECIFY) _____

RESPONSIBLE PARTY (*IF OTHER THAN THE PATIENT)*

NAME _____ RELATIONSHIP _____ HOME PHONE _____

ADDRESS _____ CITY/STATE _____ ZIP _____

SOCIAL SECURITY # _____-_____-_____ DOB _____/_____/_____

PATIENT INSURANCE INFORMATION *(Must present insurance card at time of service.)*

POLICYHOLDER NAME _____ RELATIONSHIP _____ BIRTH DATE_____

ADDRESS_____CITY/STATE_____ZIP_____

INSURANCE NAME_____POLICYHOLDER SS # _____-_____-_____

POLICY # _____ GROUP # _____COVERAGE TYPE SINGLE _____ FAMILY_____

POLICYHOLDER'S EMPLOYER _____ EMPLOYER PHONE # _____

SECONDARY INSURANCE NAME *(Medicare & HMO Patients Only-- must present card at time of service)*

POLICYHOLDER NAME _____RELATIONSHIP_____BIRTHDATE _____

ADDRESS _____ _____CITY/STATE_____ ZIP_____

INSURANCE NAME_____ POLICYHOLDER SS # _____-_____-_____

POLICY # _____ GROUP # _____HOME PHONE_____

EMERGENCY CONTACT

NAME_____RELATIONSHIP_____PHONE_____

HOW WERE YOU REFERRED TO US? _____

I GIVE PERMISSION FOR TREATMENT TO MYSELF OR DEPENDENTS. I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR CHARGES INCURRED REGARDLESS OF INSURANCE COVERAGE. I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS MY CLAIMS. I FURTHER AUTHORIZE MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PROVIDER ANY BENEFITS DUE ME UNDER MY INSURANCE PLAN

PATIENT/GUARDIAN SIGNATURE_____DATE_____

VILLA MEDICAL ARTS
10 E. Central Blvd.
Villa Park, IL 60181
(630)832-9000

Patient Name:_____

Consent to the Use and Disclosure of Medical Information for Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my medical information by ***VILLA MEDICAL ARTS*** *for* the purpose of diagnosing or providing treatment to me, obtaining payment for my treatment or to conduct healthcare operations of the practice. I understand that treatment by the practice may be denied if I do not sign this consent.

I understand that I have the right to request restrictions as to how this information is used or disclosed for treatment, payment or healthcare operations and that ***VILLA MEDICAL ARTS*** is not required to agree to the restrictions that I may request, but if the practice agrees to a restriction, the practice is bound by the agreement.

I have the right to revoke this consent, in writing, except where the practice has already made disclosures in reliance on prior consent.

I understand and have been provided with ***VILLA MEDICAL ARTS*** *Notice of Privacy Practices* that provides information about how the practice may use and disclose medical information. I understand that I have the right to review the notice prior to signing this consent.

VILLA MEDICAL ARTS has the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by *calling the office and requesting a revised copy be sent in the mail or asking for one when I am in the office.*

Signature:_____Date:_____

Relationship to Patient:_____