dr. aimee & ASSOCIATES

1 Tiffany Pointe, Suite 105
Bloomingdale, IL 60108
P: 630-980-1400 F: 630-980-1441

120 Ogden Ave, Suite 101
Hinsdale, IL 60521
P: 630-861-6070 F: 630-861-6047

dr. aimee
& ASSOCIATES
Empowering people. Changing lives.

Welcome to Dr. Aimee and Associates. In an effort to provide you with the highest level of care, and ensure a positive experience, we'd like to introduce you to our practice and the services we offer. We are a privately owned state do the art practice offering individualized comprehensive services with a personal approach. We are a team of expertly trained, exceptional providers with a holistic and pragmatic approach to your care and well being. We practice family medicine for pediatrics, adolescents and adults. We also specialize in psychiatry and medication management for patients ages ten and up; psychology and counseling for individuals, couples and families; naprapathy for all ages, and life and success coaching.

Our services emphasize whole health for the body and mind, with an emphasis on education and empowerment so you can always make an informed decision about all the treatment options available to you.

We practice what we call "Dedicated Medicine," a personalized, integrative and holistic approach to your care to create maximum health and well being for our clients and patients. We have a unique two part initial evaluation to asses both your physical and mental health needs with the provider of your choice and with our integrative health specialist so that we may create a precise and streamlined treatment plan for you, and to accelerate your health and lifestyle goals.

In order to provide your with the best care possible, we utilize a series of health screening tools prior to your first visit with us. To save you time, and to fully maximize your appointment with us, we ask that you complete the registration forms PRIOR to your scheduled appointment and bring them with you so that we may start your appointment on time. Please complete the forms thoroughly and candidly to help us more fully understand your needs. Also, please be sure to bring your insurance card and drivers license or state issued identification card.

We value you and your complete health. Our goal is to provide you with the highest level of care and to help you to establish optimal health and happiness. Thank you for your trust and confidence in us. We look forward to working together with you.

To your great health,

The team at Dr. Aimee and Associates.

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PATIENT INFORMATION

Last Name:_____ **First name:**_____ **Middle Initial:**_____

Preferred Name: _____ **Former Last Name:** _____

Sex: ☐ Male ☐ Female **Date of Birth:** _____ **Social Security #:** _____

Address: _____ **Apt #:** _____

City : _____ **State:** _____ **Zip Code:** _____

Home #: _____ **Cell #:** _____ **Work #:** _____

Consent to Text: ☐ Yes ☐ No **Email:** _____ ☐ No Email

Contact Preference: ☐ Home ☐ Work ☐ Mobile ☐ Mail ☐ Portal

Provider to see: _____

Preferred Language: _____ ☐ Declined

Race: ☐ American Indian/Alaskan ☐ Asian ☐ Black/African American
☐ Hawaiian/Pacific ☐ White ☐ Other ☐ Declined

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic Latino ☐ Declined

Marital Status: ☐ Unknown ☐ Married ☐ Single ☐ Divorced ☐ Separated
☐ Widowed ☐ Partner

How did you hear about us?

☐ Web Search ☐ Radio ☐ Ad Print - Which: _____
☐ Word of Mouth ☐ Doctor - Who: _____ ☐ Insurance _____
☐ Other _____

Guardian ☐ Not applicable **Last Name:**_____ **First name:**_____ **MI:** _____

Emergency Contact: Name: _____

Relationship: ☐ Spouse ☐ Parent ☐ Child ☐ Singling ☐ Friend ☐ Cousin ☐ Guardian ☐ Other

Home #: _____ **Cell #:** _____ **Work #:** _____

Employer: _____ **Phone:** _____

Guarantor (Name to whom statements are sent)

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

DOB:_____

Mailing Address: ☐ Same as patient's address

Street : _____

City:_____ **State:**_____ **Zip Code:**_____

Phone: _____ **Email:** _____ ☐ Declined

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Financial Policy

Thank you for choosing Dr. Aimee & Associates to be of service to you. Please understand that our billing is done according to the contractual obligations we have with your insurance company and we must be in compliance with federal and state laws regarding financial transactions related to providing medical care.

PAYMENT FOR SERVICES IS EXPECTED AT THE TIME OF SERVICE.

We do NOT accept worker's compensation and Motor Vehicle insurance claims.

Please do not discuss or negotiate your copays or deductibles with your provider.

Please ask to speak with our financial advisors who better understand the insurance requirements, the rules and regulations that we must comply with, and how we can best help you with your financial considerations.

Patient Obligations:

- Copays must be paid at time of service.
- Patients are responsible for their deductibles, coinsurance, out of pocket expenses, and any other agreed to services not covered by your insurance.

Collection Policy: Any unpaid balances over 90 days will be forwarded to a collections agency unless other arrangements have been made with our financial counselor.

We are committed to serving those in need but we must do so in a legal manner that will also not jeopardize our business and deny others access to the health care they deserve.

Acknowledgement

- I acknowledge full financial responsibility for services provided to me by Dr. Aimee & Associates.
- I understand that I am responsible for prompt payment of any portion of the charges not covered by insurance, including copayments, coinsurance, out of pocket expenses and deductibles.
- I understand copayments are due at the time of service as well as any prior balance I may owe.
- I understand that under provisions of HIPAA (Health Insurance Portability and Accountability Act), my insurance company and /or employer group plan administrator may be notified if I fail to fulfill my financial obligations for payment.
- I agree to all reasonable attorney fees and collection costs in the event I default on payment of my charges.
- I also give my consent for the release of billing information and for the direct payment of authorized insurance benefits paid on my behalf to Dr. Aimee & Associates.

Patient's Name: (Please print) _____ DOB: _____

Patient's Signature: _____ Date: _____

Rev 042817

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers/collectors.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

The Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information has been made available to me. 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 confidential information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

It is the policy for Dr. Aimee & Associates to inform patients of pertinent test results. We may also be asked to discuss your health information with other family members or a close friend. Laws prevent us from leaving any messages regarding these results without your permission.

Notification/Permission to call and/or leave messages:

Please check all acceptable options regarding notification of test results or health information and provide current phone numbers.

☐ I will call the office, please do not call with results.

☐ Patient Only Phone: _____

☐ Spouse Name: _____ Phone: _____

☐ Child Name: _____ Phone: _____

☐ Other Name: _____ Phone: _____

☐ And/or to: _____ Phone: _____

By signing below I acknowledge the following:

- I have been provided with a copy of the Notice of Privacy Practices.
- I give Dr. Aimee & Associates the authority to access my medication history automatically from pharmacy benefit managers (PBMs).
- I give consent to call me using automated phone calls or send text messages on my cell phone.

Patient's Name: (Please print) _____ DOB: _____

Patient's Signature: _____ Date: _____

OFFICE USE ONLY : I attempted to obtain the patient's signature in acknowledgment of this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below.

Date: _____ Name: _____ Initials: _____ Reason:_____ Rev 042817

Dr. Aimee & Associates @ Affiliated
One Tiffany Pointe, Suite 105
Bloomingdale, IL 60108
Phone: 630-980-1400 Fax: 630-980-1441

Client Name: _____
Credit Card will be run on the last Thursday of the month. Only patient balances will be run.

Billing Policies:
Please carefully review all the billing policies below and initial where indicated. Complete all fields in the "Credit Card Information" section of this form. This form must be completed and signed at the time of your initial session.

Overview
Why Does Dr. Aimee & Associated have a credit card policy? By utilizing your credit card information for balances due, we will be able to process payment more efficiently.

We are currently sending statements for your unpaid balances. By reducing the number of statements printed and mailed each month, we will be lower billing costs by saving on paper, time and postage. These savings allow us to keep services affordable and to keep your fees to a minimum.

We require that a valid credit card be kept on file for all clients. If you do not wish to have your credit card charged, you must provide an alternate form of payment at time of service or contact our billing department with an alternate form of payment upon receipt of the Explanation of Benefits (EOB) from your insurance company.

Please contact our billing department with any questions at (630) 980-1400.

Policies

Initial Here _____ **Co-Pay**

- All payment for co-pays are due at the time of each appointment.
- If an alternative form of payment (i.e. cash or check) is not received at time of service, your credit card will be manually charged for any fees.

Initial Here _____ **Cancellation Policy**

- We require a 24 hour notice for all cancellations.
- Your credit card will be charged $75.00 for all cancellations/no-shows with less than 24 hours' notice.

Initial Here _____ **Insurance (Payments, Deductibles, Etc.)**

- It is the client's responsibility to cover any deductible and all co-payments.
- Upon receipt of the EOB from your insurance company, we will apply the insurance payment to your account and charge your credit card for the client balance due for each applicable date of service. A copy billing statement and credit card receipt will be mailed promptly.
- WE will submit medical claims to the primary and secondary (if applicable) insurance company. There is no guarantee that the services provided by us will be covered and paid for by your insurance.
- Insurance companies typically take 30-90 days to process claims. When the claim is processed, the insurance company will mail an EOB to both the member (you) and to the provider (us).
- Not all services are covered by insurance plans; it is the client's responsibility to know their health benefits. Please contact your insurance provider to obtain the benefit details of your policy.

Credit Card Information

Type of Credit Card: ☐ Visa ☐ MasterCard ☐ Discover

Credit Card #: _____ Expiration Date: _____

3 Digit Security Code (Found on back of card: _____ Billing Street #: _____ Billing Zip Code _____

I hereby authorize Dr. Aimee & Associates @ Affiliated to charge my credit card for any unpaid balance, including missed or cancelled appointment fees. The signature below will serve as the authorization for said charges. By signing this form, I understand that my credit card will continue to be charged until my account balance for services rendered is $0.00.

_____ _____ _____
Signature of Card Holder Printed Name of Card Holder Today's Date