7 Hills Healthcare Center

455 E. Main St.
East Dundee, IL 60118
Ph: (847) 428-2273
Fax: (847)428-3128

8419 S. Cottage Grove Ave
Chicago, IL 60619
Ph: (773) 651-0200
Fx: (773) 651-8968

Welcome to 7 Hill Health Care Center. Thank you for completing both sides of this Patient Registration Form. If you would like to take home copies of any forms completed today, please just ask your registrar.

Last Name_____**First Name**_____**MI**_____

SSN_____-_____-_____**SEX** Male / Female **DOB**_____/_____/_____

Address_____**City**_____**Zip Code**_____

Phone Number (_____) _____-_____ **Employer**_____

Who is policy holder on your primary insurance? me spouse parent

If primary policy holder is a spouse of parent, then please provide the following:

Last Name_____**First Name**_____**MI**_____

Address (If other than yours)_____

Date of Birth_____/_____/_____**Employer**_____**SSN**_____

Who is the physician who referred you to our practice?_____

Emergency contact person name:_____Phone (_____) _____-_____

I am interested in receiving email information regarding 7 Hills Health Care Center, or any series, seminars, or publications they may offer on digestive health or digestive disease management. I understand that my email address will not be provided to any party outside of the practice. Yes No Email address_____

In accordance with Illinois law, I understand that if any person employed by 7 Hills Health Care Center, is directly exposed to my body fluids in any manner which may transmit the human immunodeficiency virus (HIV), that I may be tested for infection with HIV. I further understand that Illinois law allows for the release of these test results to the person who is exposed to my body fluids.

(Public Health (410 ILCS 305/7))

I also agree that if any person employed by 7 Hills Health Care Center, is directly exposed to my body fluids in any manner which may transmit viral hepatitis, that I may be tested for infection with viral hepatitis. I further agree to the release of these test results to the person who is exposed to my body fluids.

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Initial

Authorization to Leave Messages & to Contact Patient

I hereby authorize 7 Hills Health Care Center, to leave a message on my home voice mail, answering machine, or other electronic device, or with a person who answers my home phone, in regards to my health, my appointment, or my financial obligations to 7 Hills Health Care Center. I hereby authorize 7 Hills Health Care Center to contact me for appointments (ie. Evaluations, visits, lab results, vision screenings, routine maintenance, physicals, and chronic disease management).

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Initial

Please turn form over

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Assignment of Insurance Benefits

I hereby authorize payment to 7 Hills Health Care Center or any reference laboratory, for benefits herein specified and otherwise payable to me for any services rendered subsequent to this date, and for such other charges as may be made by previously mentioned providers of medical care. This assignment will remain in effect until revoked by me in writing. A copy of this assignment is to be considered as valid as the original.

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Initial

Authorization to Release Information

I hereby authorize 7 Hills Health Care Center to release my information to any reference laboratory, any medical imaging center, any pharmacies, any health professional, any home health agency/hospice, companies, associations, employee groups, government agencies or you third party payors and their agent or employee, either by mail, fax, telecommunication or electronically as maybe necessary for completion of my claims and care. If said records should be received by another party in error, I absolve the practice of any liability related to such submission of said records.

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Initial

Hospital Admission

7 Hills Health Care Center's Physicians do not go to hospitals, but have hospitalists group contracted and would be incharge of you hospital addmissiona and care. If you have any more questions please contact our office (847) 428-2273.

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Initial

HIPAA Information

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office. What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, employees, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I certify that the information provided on both sides of this form are correct to the best of my knowledge. I have read and understand the above and duly authorize 7 Hills Health Care Center and/or its appointees to execute the above and its terms.

Patient Signature:	Date:
If patient is a minor <18 years of age on date of service signature of parent or guardian is required:	If above patient has granted power of attorney, then agent must sign: