

**Lincoln Park Family Physicians SC**

1317 W Diversey Pkwy, Chicago, IL 60614 • P-773-665-9355 • F-773-665-0403 • [www.lpfamilymd.com](http://www.lpfamilymd.com)

**PATIENT DEMOGRAPHIC FORM**

**PATIENT INFORMATION:**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Sex:  M  F  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Birth date: \_\_\_\_\_ Marital Status:  S  M  W  D Maiden Name: \_\_\_\_\_  
Social Security : \_\_\_\_\_ Occupation: \_\_\_\_\_  
Employer Name: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_  
Email Address: \_\_\_\_\_

**INSURANCE INFORMATION:**

Primary Ins. Co. Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Member ID: \_\_\_\_\_ Group: \_\_\_\_\_  
Medical Claims Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Secondary Ins. Co. Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Member ID: \_\_\_\_\_ Group: \_\_\_\_\_  
Medical Claims Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**INSURANCE POLICYHOLDER'S INFORMATION:**  Self  Parent  Spouse  Other

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Sex:  M  F  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Social Security: \_\_\_\_\_ Birth date: \_\_\_\_\_ Phone: \_\_\_\_\_  
Employer Name: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

**BILLING INFORMATION:**  Self  Parent  Spouse  Other

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Sex:  M  F  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Social Security: \_\_\_\_\_ Birth date: \_\_\_\_\_ Phone: \_\_\_\_\_

**EMERGENCY CONTACT:** Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**PHARMACY:**

Local Pharmacy: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Mail Order Pharmacy: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

By signing below I acknowledge that I consent to and understand Lincoln Park Family Physicians Notice of Privacy Practices and Notice of Patient Responsibilities. I hereby authorize payment directly to Lincoln Park Family Physicians for benefits otherwise payable to me. I understand that I am financially responsible for charges not covered by this authorization. I also authorize Lincoln Park Family Physicians to release any information acquired in the course of my examination or treatment in the processing of these claims.

**PATIENT/GUARDIAN SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

## HEALTH HISTORY AND DATABASE

Please complete both sides of this form completely. All information is confidential and is reviewed by your physician.

Name \_\_\_\_\_  
 Today's Date \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_

What is the reason for your visit?

Place a ✓ next to conditions you have now or have had in the past.					
<input type="checkbox"/> AIDS or HIV positive	<input type="checkbox"/> Depression	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Psychiatric disorder		
<input type="checkbox"/> Alcohol or drug addiction	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Rheumatic fever		
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diverticulosis	<input type="checkbox"/> Kidney stones	<input type="checkbox"/> Scarlet fever		
<input type="checkbox"/> Anorexia	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Liver disease	<input type="checkbox"/> Stroke		
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Measles	<input type="checkbox"/> Suicide attempt		
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Migraine headaches	<input type="checkbox"/> Thyroid disorder		
<input type="checkbox"/> Asthma	<input type="checkbox"/> Goiter	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Tuberculosis		
<input type="checkbox"/> Breast disorder	<input type="checkbox"/> Gout	<input type="checkbox"/> Multiple sclerosis	<input type="checkbox"/> Ulcers		
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Heart problem	<input type="checkbox"/> Mumps	<input type="checkbox"/> Urinary infections		
<input type="checkbox"/> Bulimia	<input type="checkbox"/> Heart attack	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Venereal disease		
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Pneumonia			
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hernia	<input type="checkbox"/> Polio			
<input type="checkbox"/> Chicken pox	<input type="checkbox"/> Herpes	<input type="checkbox"/> Prostate disorder			

  

List Hospital Admissions, Operations, Illnesses, and Serious Injuries (not including pregnancies)	Year	Illness or operation	Year	Illness or operation	

  

List all medications you are now taking including over the counter medications, supplements and vitamins.	Medication allergies	Vaccine	Year of last	Test/exam	Year of last	
			Tetanus		Tuberculosis	
			Flu Shot		Cholesterol	
			Pneumonia		Eye exam	
Date of last complete physical? _____						

  

**Females only-please complete.**

Number of pregnancies	Birth control method
Number of live births	Date of last menstrual period
Number of abortions	Date of last pap smear
Number of miscarriages	Date of last mammogram

  

**Family history**      **If any blood relative has suffered any of the following, please indicate below with a ✓.**

Family history	Mother	Father	Brother or Sister	Child	Grandparent
Alcohol abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeds easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Symptoms: Mark (c) for current problems or check (✓) for past problems**

- |   |   |  |   |
|---|---|--|---|
| <p><b>Constitutional</b></p> <input type="checkbox"/> Chills<br><input type="checkbox"/> Chronic fatigue<br><input type="checkbox"/> Fever<br><input type="checkbox"/> Loss of appetite (recent)<br><input type="checkbox"/> Sweats<br><input type="checkbox"/> Weight gain<br><input type="checkbox"/> Weight loss | <p><input type="checkbox"/> High blood pressure<br/> <input type="checkbox"/> Irregular pulse/palpitations<br/> <input type="checkbox"/> Leg pain when walking<br/> <input type="checkbox"/> Rapid heartbeat<br/> <input type="checkbox"/> Swollen ankles<br/> <input type="checkbox"/> Varicose veins/phlebitis</p> <p align="center"><b>Respiratory</b></p> <input type="checkbox"/> Asthma or wheezing<br><input type="checkbox"/> Bronchitis or chronic cough<br><input type="checkbox"/> Pneumonia or pleurisy<br><input type="checkbox"/> Shortness of breath <p align="center"><b>Gastro-intestinal</b></p> <input type="checkbox"/> Abdominal pain<br><input type="checkbox"/> Bloating<br><input type="checkbox"/> Bloody or tarry stools<br><input type="checkbox"/> Change in bowel habits<br><input type="checkbox"/> Constipation<br><input type="checkbox"/> Gallbladder problem<br><input type="checkbox"/> Heartburn<br><input type="checkbox"/> Hemorrhoids<br><input type="checkbox"/> Hernia<br><input type="checkbox"/> Jaundice or Hepatitis<br><input type="checkbox"/> Persistent nausea or vomiting<br><input type="checkbox"/> Rectal bleeding<br><input type="checkbox"/> Vomiting blood <p align="center"><b>Allergy/Immunity</b></p> <input type="checkbox"/> Hay fever or allergies<br><input type="checkbox"/> Hives<br><input type="checkbox"/> Severe allergic reaction <p align="center"><b>GU</b></p> <input type="checkbox"/> Decrease in urine force/flow | <p><input type="checkbox"/> Loss of bladder control<br/> <input type="checkbox"/> Painful or frequent urination<br/> <input type="checkbox"/> Urethral discharge<br/> <input type="checkbox"/> Venereal disease</p> <p align="center"><b>Males only</b></p> <input type="checkbox"/> Discharge from penis<br><input type="checkbox"/> Erectile difficulties<br><input type="checkbox"/> Lump in testicles<br><input type="checkbox"/> Prostate cancer<br><input type="checkbox"/> Sore on genitals <p align="center"><b>Females only</b></p> <input type="checkbox"/> Abnormal pap smear<br><input type="checkbox"/> Irregular cycle<br><input type="checkbox"/> Menstrual flow is heavy<br><input type="checkbox"/> Painful intercourse<br><input type="checkbox"/> Painful menstruation<br><input type="checkbox"/> Vaginal discharge <p align="center"><b>Skeleton and Muscles</b></p> <input type="checkbox"/> Arthritis or rheumatism<br><input type="checkbox"/> Back pain<br><input type="checkbox"/> Bone fracture or joint injury<br><input type="checkbox"/> Cold feet<br><input type="checkbox"/> Gout<br><input type="checkbox"/> Muscle weakness<br><input type="checkbox"/> Osteoporosis or thin bones<br><input type="checkbox"/> Pain, Location:<br><input type="checkbox"/> <b>Skin</b><br><input type="checkbox"/> Change in moles<br><input type="checkbox"/> Easy bruising<br><input type="checkbox"/> Lump in breast or nipple<br><input type="checkbox"/> Nipple discharge | <p><input type="checkbox"/> Non-healing sore<br/> <input type="checkbox"/> Persistent rashes<br/> <input type="checkbox"/> Psoriasis or eczema<br/> <input type="checkbox"/> Skin cancer or tumors</p> <p align="center"><b>Neurological</b></p> <input type="checkbox"/> Dizzy or room spins<br><input type="checkbox"/> Frequent or severe headaches<br><input type="checkbox"/> Memory loss<br><input type="checkbox"/> Numbness/tingling sensations<br><input type="checkbox"/> Seizures<br><input type="checkbox"/> Stroke<br><input type="checkbox"/> Tremor / hands shaking <p align="center"><b>Psychiatric</b></p> <input type="checkbox"/> Depression<br><input type="checkbox"/> Excessive moodiness<br><input type="checkbox"/> Mental illness<br><input type="checkbox"/> Nervousness<br><input type="checkbox"/> Phobias<br><input type="checkbox"/> Sleeping difficulty <p align="center"><b>Endocrine</b></p> <input type="checkbox"/> Excessive hunger/thirst<br><input type="checkbox"/> Flushing/menopause<br><input type="checkbox"/> Frequently cold<br><input type="checkbox"/> Frequently hot<br><input type="checkbox"/> Hot Flashes <p align="center"><b>Hematologic/Lymphatic</b></p> <input type="checkbox"/> Anemia<br><input type="checkbox"/> Swelling/lump in armpits<br><input type="checkbox"/> Swelling/lump in groin<br><input type="checkbox"/> Swelling/lump in neck |
|---|---|--|---|

**Health Risk Assessment (Please describe any that apply.)**

Tobacco use	Caffeinated beverages
Alcohol use	Occupation
Drug use	Exposure to hazardous substances
Intravenous drug use	Regular exercise
Do you have any special needs related to cultural beliefs? (i.e. diet, blood transfusions, religious practices- if so describe)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any special educational or communication needs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any physical developmental or learning disabilities?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any food allergies or intolerances?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please check (✓) next to items you have in your household.	<input type="checkbox"/> Smoke detector
	<input type="checkbox"/> Firearms or weapons
	<input type="checkbox"/> Carbon dioxide detector
	<input type="checkbox"/> Fire extinguisher
Do you routinely wear your seatbelt?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you wear a helmet while biking or rollerblading?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been a victim of domestic violence abuse or sexual assault?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you currently sexually active?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you practice safe sex?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Number of partners in; 1) last year, 2) lifetime?	
Information completed by patient's family member or significant other?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Previous physician and or office location with your medical records?	
Is English your primary language? If not, what is?	<input type="checkbox"/> Yes <input type="checkbox"/> No
The information above is accurate and complete to the best of my knowledge.	
Signature	Date
Reviewed	Date

## Lincoln Park Family Physicians SC

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### NOTICE OF PATIENT RESPONSIBILITIES AND POLICIES

**APPOINTMENT HOURS:** Appointment times are on Mondays and Thursdays between 10:00am and 6:30pm, Tuesdays and Wednesdays between 9:00am and 4:30pm, and on Fridays between 9:00 am and 11:30am. To schedule an appointment please call our office at 773-665-9355 on Mondays and Thursdays between 8:30am and 6:45pm, Tuesdays and Wednesdays between 8:30am and 4:45pm, and on Fridays between 8:30 am and 11:30am

**LATE APPOINTMENT ARRIVAL:** We strive to see all patients on time for their scheduled appointment. If you are a returning patient please plan to arrive at least 10 minutes prior to your scheduled appointment to check in. New patients please arrive 30 minutes prior to your appointment to complete the new patient paperwork. If you arrive 5 or more minutes late for your appointment time, you may be asked to reschedule for the next available appointment time.

**MISSED APPOINTMENT:** A missed appointment is when you fail to show up for an appointment without a phone call, fail to cancel within one business day or arrive 15 minutes past your scheduled appointment time.

If you miss your appointments, you compromise the care that we are able to provide you and other patients that may have needed an appointment.

Effective May 1<sup>st</sup> 2011 all Missed Appointments will be charged a \$25 fee billed to your account that is non-covered by Insurance.

**PRESCRIPTION REFILL GUIDELINES:** We have developed a policy for handling prescription refills in the hope that our time may be spent caring for our patients and delivering the best care possible. One way we try to keep our medical assistants available to take patient phone calls with urgent problems and questions is by limiting pharmacy and medication refill calls. Please notify your pharmacy if you are requesting refills and have them fax your refill request to our office at 773-665-0403. Prescription refills are only done during our regular business hours and will be responded to within 72 hours. When a refill by phone is necessary, please be prepared to provide the name of the medication, strength, dosage, and the pharmacy number.

**PHONE MESSAGES:** In order to provide the best care possible to our patients and allow our scheduled patients to be seen by our medical providers without multiple interruptions our medical staff are available to take messages for our medical providers during office hours. When leaving a message please indicate your name, the patient's name, the reason for your call, and phone number where you can be reached. The medical staff will alert the medical provider of a message and will call the patient back with the providers response in a timely manner. Please be aware that certain messages may require a visit with a medical provider.

**AFTER HOURS:** If you have an urgent issue after regular business hours, please call the main office number. The operator will take your name, phone number, reason for call, and help you reach our on-call medical provider. The on-call medical provider returns patients phone calls as soon as possible and assists them with urgent medical issues that cannot wait until regular business hours. In case of emergency, please call 911.

**LABORATORY TESTING:** Please call in advance to schedule an appointment for any lab tests ordered by a medical provider. In order to ensure accurate laboratory testing is done, a patient must have an order for lab tests from one of our medical providers in their chart, a written order from another medical provider's office, or obtain approval for requested lab work from a medical provider in the office prior to scheduling an appointment. We use ACL for our lab services; however a patient that does not wish to use ACL must request an alternate lab service prior to any lab work. The lab service may bill your insurance separately for any test we do not bill for in our office. The turnaround time on lab results can vary, however routine labs usually take 2-3 business days, while cultures and biopsies generally take 1-2 weeks to receive the results. After lab results have been received and reviewed by the medical provider one of our medical staff will call the patient to inform them of their results. In order for an HIV test, and occasionally other tests to be performed, a return visit with a medical provider is required.

**PATIENT FORMS:** We understand that there are forms that may need to be completed by one of our staff and/or medical providers. These forms include, but are not limited to disability forms, Family Medical Leave forms, Attending Physician Forms, school forms, itemization of charges, etc. In order for our office to properly complete any forms on our patients' behalf we require the patient to complete all patient portions of any form and provide any information needed to assist the provider in completing the form prior to submitting the form to our office. Please allow 6 business days for our office to complete any forms.

**MEDICAL RECORDS:** In order to best serve our patients we recommend our patients request copies of their lab or test results when they are given the results by one of our staff members, or providers. A copy of a single test or a lab is no charge to our patients. Please be aware that in order to receive a copy of multiple pages of your medical records a completed release form must be submitted to our office. This service will be out sourced to our medical records vendor and there may be a charge. Depending on when a patient was last seen medical records can take up to 30 days for our office to process the request, however recent patient's records are usually copied on Tuesday following the submitted request. Please refer to our medical records request form for more information.

**Lincoln Park Family Physicians SC**

## **NOTICE OF PATIENT RESPONSIBILITIES AND POLICIES**

**FINANCIAL RESPONSIBILITY:** As a patient it is in your best interest to know and understand your insurance plan benefits and responsibility for any deductibles, co-insurance, or co-payment amounts prior to any visit. Please have your current insurance card with you at all times, as well as a photo ID. You are responsible to notify us of your insurance plan and to provide us the necessary information about your insurance policy. It is your responsibility to know your insurance company's patient responsibilities and procedures. Not all services are covered in all insurance contracts. If your insurance plan does not cover a service, or procedure, you are responsible for payment of these charges. To find out what your insurance plan covers and what your financial obligation may be, call the customer service or member services department of your insurance company (the phone numbers are on your insurance card). If you do not have any insurance coverage for the visit please notify us when you schedule the appointment and a time of service payment will be due at the time of visit. Resolution of any outstanding balance is expected prior to obtaining additional services from Lincoln Park Family Practice. Please refer to the Lincoln Park Financial Policy which is on our website, or at the front desk of the office for more information.

**PREAUTHORIZATION AND REFERRAL GUIDELINES:** Some insurance plans may require preauthorization, or referrals for services and tests. It is your responsibility to know your insurance company's patient responsibilities and procedures. If proper insurance procedures are not followed, you may be liable for full payment of the bill. If your insurance company requires a referral and/or prior authorization you must contact our office at least 6 business days prior to seeing a specialist, or having any testing done. Please refer to the Lincoln Park Financial Policy for more information.

**HIPPA NOTICE OF PRIVACY PRACTICES:** Protecting the privacy of your health information of our patients is important. Within the Lincoln Park Family Physicians Notice of Privacy Practices binder we are pleased to tell you about a federal law that is designed to help protect the privacy of health information and explains our use of your medical or health information. The law is known as the HIPAA Privacy Rule. The Privacy Rule requires us to give you access and copies of our Notice of Privacy Practices. Prior to signing acknowledgment of the privacy rule you have a right to access, review, and request copies of Lincoln Park Family Physicians Notice of Privacy Practices.

**USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:** In accordance with the Lincoln Park Family Physicians Notice of Privacy Practices, Lincoln Park Family Physicians S.C. may use and disclose protected health information about patients to carry out treatment, payment, and healthcare operations. Lincoln Park Family Physicians S.C. may call a patient's home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out healthcare operations, such as appointment reminders, insurance items, collection calls, and any call pertaining to my clinical care, including laboratory results among others. Lincoln Park Family Physicians S.C. may mail to a patient's home or other designated location any items that assist the practice in carrying out healthcare operations, such as appointment reminder cards and patient statements as long as they are marked confidential. A patient may revoke their consent to disclose protected health information in writing except to the extent that the practice has already made disclosures in reliance with their prior consent and upon a patient revoking consent Lincoln Park Family Physicians S.C. may decline to provide treatment to the patient.

**Please do not hesitate to contact our office with any questions, or comments.**

# Financial Policies And Procedures

At Lincoln Park Family Physicians (LPFP), we care for patient finances as well patient health. In an effort to inform patients of our financial policies and procedures, we provide this handbook.

## We are Here to Help

Thank you for taking the time to read our policies. Patients should not hesitate to call with any questions regarding this handbook. We wish to work as a team with our patients to ensure insurance claims are processed accurately.

## 1.) Prepare for Your Visit

Be sure to bring these items every visit:

- Insurance Card
- State/Photo ID
- Cash / Check / Credit card
- Information required to fill out forms (see Required Information section below)

New patients are advised to arrive 30 minutes prior to appointment time to fill out paperwork. If patients have the internet and a printer, [new patient paperwork](#) can also be printed, filled out, and brought in for the appointment.

## REQUIRED INFORMATION

Be prepared to provide:

- Patient name, address, phone number, gender, date of birth, social security number, insurance ID and group number.
- Subscriber name, address, phone number, gender, date of birth, social security number, relationship to patient
- If patient is not the Responsible Party, provide the Responsible Party's name, address, phone number, gender, date of birth, social security number, and relationship to patient. Be sure to tell the front desk that bills are supposed to be sent in the Responsible Party's name
- For any out of state Blue Cross Blue Shield plans, please provide the state the policy is from or the plan code. Both items should be found on the patient's insurance ID card.

If any of this information is not provided, payment in full will be required at time of service.

## CONFIDENTIALITY

Patient information is private and protected. LPFP is HIPPA compliant.

## TIME OF SERVICE PAYMENTS

The following are expected at time of service:

- Copays
- Self-insured patient payments
- Any balances aged past 30 days
- Payment for services rendered to patients whose insurance is out of network or out of the country
- Payment for services that are non-covered due to policy exclusions or a pre-existing condition
- Payment in full for services rendered to patients whose insurance could not be verified or who refused to provide aforementioned required information

## UNDERSTANDING YOUR BENEFITS

It is the patient's responsibility to understand his/her benefits and to keep us informed. This helps us better accommodate the patient at time of service and helps the patient to better anticipate any out of pocket expenses. Please be familiar with the following:

- Exclusions on the policy, which can include pre-existing conditions
- Dollar or service maximums on any services
- Whether there is a deductible, how high it is, and what services it will be applied to
- Reason for appointment, with regard to whether it is a "Well visit" or a "Sick Visit". A "Well Visit" will be covered by Preventative Benefits and can include, but is not limited to, any preventative tests, physical exams, and immunizations. A "Sick Visit" will be covered by Office Visit Benefits and can include, but is not limited to, any visit you have with a provider that addresses a present complaint or condition. Please note whether your benefits cover these services.
- Whether your plan covers mental health benefits

## 2.) UNDERSTANDING THE INSURANCE CLAIM PROCESS

How does it work?

1. See the provider
2. Office sends the claim to the insurance company
3. Insurance company processes the claim
4. Insurance company sends the patient and provider an Explanation of Benefits
5. Office's billing department sends a bill to the patient for remainder of balance

## EXPLANATION OF BENEFITS (EOB)

Explanation of Benefits documents are sent by payors to both enrollees and providers after a claim is processed. This document illustrates:

- Provider payment
- Write offs
- Patient responsibility

However, an EOB is not a bill; it is simply an explanation of how benefits were applied. The patient's bill will come from LPFP. Please pay promptly.

## CLAIM PROCESSING

There are four ways a patient can incur a balance:

1. Copay
2. Coinsurance
3. Deductible
4. Non-covered charges due to exclusions/maximums on policy

One or all of these balances can be incurred by any one claim simultaneously; it depends on the patient's policy. Patients are encouraged to review their EOBs to ensure the insurance company processed their claim appropriately according to their insurance benefits. [See the definitions](#) at the end of this page for a better explanation of each of these terms.

## ADDITIONAL INFORMATION

Often, before insurance companies can correctly process a claim, they request additional information. This requested information can include, but is not limited to:

- Update of Coordination of Benefits (COB)
- The date and accident/injury occurred
- Onset of an illness/condition
- Student Status
- General records update
- Additional information may also be requested from a provider other than us

It is the patient's responsibility to provide the additional information to the insurance company. Patients will receive a notification from their insurance and a letter/statement from us. Thirty days are allowed for providing said requested information to the insurance company before we turn the entire balance over to patient responsibility.

## 3.) PATIENT FINANCIAL RESPONSIBILITIES

### PATIENT STATEMENTS

Patient statements generally go out around the 15th of every month. Patients will receive a statement from us with the remaining balance once we receive a reply from the insurance company. Payment is due within 30 days of receiving the statement.

### PAYMENT OPTIONS

Our office accepts Visa, MasterCard and American Express. Our office also accepts check or cash. Please do not send cash by mail. There will be a \$50.00 fee for all returned checks. You can also [make payments through our website](#).

### THIRD PARTY BILLS

In addition to receiving bills from us, patients may also receive bills for services provided by a third party. These charges may be for lab, radiology, hospital, or other services. While your provider orders these services, said third parties provide them and payment should be made directly to the third party. It is advised that patients call the third party directly with any questions.

### PAYMENT PLANS

Sometimes, unexpectedly large balances are incurred. If a balance cannot be paid in full, patients may call the office to set up a payment plan within 10 days of receiving a statement.

How a payment plan works:

- LPFP uses an online system to set up a payment plan that automatically deducts from an account designated by the patient
- Only a credit card or a debit card with a Visa/Mastercard logo can be used for this online system
- A maximum of three deductions can be made with an amount no less than \$50.00 per deduction
- Billing will negotiate with the patient the amount to be deducted, the date of first deduction, and the dates of subsequent deductions (the date of deduction has to be the same every month, i.e. the first of every month). Deductions are possible monthly or bi-monthly and will continue until the balance is paid down.
- There is a service fee of \$1.50 each time a deduction is made, which is added to the total balance.
- If a plan defaults due to inconsistent funds, it is the patient's responsibility to either call with a new credit card or pay the remaining balance in full at that time.
- Patients will still receive monthly statements to help track balance status.

Patients may consider paying LPFP the balance in full with a credit card, so as to make payments at their discretion.

## OVERDUE BALANCES

We urge patients to keep their accounts current and in good standing with our office. Sending in partial or inconsistent payments is not acceptable and it will not keep overdue accounts from referral to a collection agency. If a payment cannot be made on time, it is crucial that patients call to set up a payment plan. All account balances past due will be referred to a collection agency.

## RECEIPTS

Patients receive receipts for any payment made at the front desk. It is encouraged that patients keep these receipts for their own records. Patients will receive a receipt in the mail when credit card information is sent by mail to pay for outstanding balances.

## 4.) DEFINITIONS AND COMMONLY USED TERMS

**ACCEPT ASSIGNMENT:** Accept assignment means the provider has agreed to accept an in-network insurance company's fee schedule for services rendered.

**ALLOWED AMOUNT:** Contracted dollar amount a provider accepts as payment from in-network insurance company. This amount is the billed amount reduced by the provider discount.

**BILLED AMOUNT:** Dollar amount charged to an insurance company for services provided to a patient on a service date.

**COINSURANCE:** An insurance policy provision under which the insurer (insurance company) and the insured (patient) share costs incurred after the deductible is met, according to a specific formula. Coinsurance is expressed as a percentage or pair of percentages generally with the insurer's portion stated first. The maximum percentage the insured will be responsible for is generally no more than 50%. Coinsurance indicates how an insurer and an insured will share the costs of a bill that exceeds the insurance policy's deductible up to the policy's stop loss. Once the insured's out-of-pocket expenses equal the stop loss, the insurer will assume responsibility for 100% of any additional costs.

**COPAY:** The amount an insured person is expected to pay for a medical expense at the time of the visit.

**DEDUCTIBLE:** The amount that an insurance policy holder has to pay out-of-pocket before reimbursement begins in accordance with the coinsurance rate.

**DEPENDENT:** An individual who is covered under the subscriber's insurance policy. Generally this individual is related to the subscriber; i.e. spouse, child.

**IN NETWORK:** Providers that have a contractual agreement with the insurance company. Being in-network means that the provider has agreed to a discounted rate for members of the contracted insurance carrier.

**NON-COVERED/INELIGIBLE:** Services that are not covered by the insured's insurance policy. The resulting charges are patient responsibility.

**OUT OF NETWORK / NON-PARTICIPATING INSURANCE:** Providers that DO NOT have a contractual agreement with the insurance company. Out of network providers will still submit insurance claims for the patient, however, the insurance company will reimburse the patient directly. Patients can still be seen by an out of network provider; however, a higher out of pocket expense can be accrued.

**PROCEDURE CODE:** Numbers or alphanumeric codes used to identify specific services provided by a medical professional. Also known as a CPT code (Current Procedural Terminology).

**PROVIDER DISCOUNT:** Difference between the billed amount and the allowed amount. Also known as a write-off or the amount above the "contracted rate" of provider payment.

**PROVIDER PAYMENT/CLAIMS PAYMENT:** Dollar amount paid by an insurance company to the provider for a date of service.

**PROVIDER:** An organization or person who delivers health care professionally and systematically. This can include, but is not limited to, doctors, nurse practitioners, hospitals, labs, and specialists.

**RESPONSIBLE PARTY:** The party responsible for paying a patient's bills.

**SELF-INSURED, SELF-PAY:** A patient who has no insurance coverage is considered "self-insured". Self-insured patients are welcome at LPFP and are encouraged to inquire about payment arrangements.

**SERVICE DATE:** The date the patient was seen by the provider. Also known as Date of Service.

**SUBSCRIBER:** The party whose name the insurance policy is under; the insurance policy holder.

We thank all our patients for their cooperation. Again, do not hesitate to call with questions.

Thank you,

Lincoln Park Family Physicians