

## **ELGIN INTERNAL MEDICAL ASSOCIATES, S.C.**

**DENNIS M. FLYNN, M.D.  
RICHARD M. BAILEY, M.D.  
JOHN T. FIELDLER, M.D.  
MARIE E. SCHLENTZ, D.O.  
MADHUKAR DAMERA, M.D.**

**745 FLETCHER DRIVE, SUITE 101  
ELGIN, ILLINOIS 60123  
TELEPHONE: 847-742-3525**

Dear Patients:

We appreciate the trust you put in your doctors at Elgin Internal Medical Associates. As you know, medicine is practiced in an ever-changing environment; the goal being to constantly improve patient care.

In our efforts to meet our goal, Elgin Internal Medical Associates uses hospitalists to enhance our delivery of care. Hospitalists are physicians who work in tandem with your primary care physician to manage your care if you are ever hospitalized. It is a relatively new state-of-the-art medical subspecialty.

In May, 2005 Elgin Internal formed an alliance with Inpatient Consultants of Illinois. This group of hospitalists are well trained, board certified internists with expertise in patient hospital management. They work solely in a hospital environment where they are available for one on one care, twenty-four hours a day, seven days a week. As your primary care physicians, we feel these doctors are an excellent adjunct to your medical care and our medical practice. Since their practice is limited to hospital work, they are more readily available in emergent situations, are able to order tests or x-rays and translate the results to you in a timelier manner. We will be in close contact with the hospitalists managing our patients' care. We feel our association with the physicians of IPC will be a great benefit to our patients when they are in need of inpatient hospital care.

Another benefit for our patients is that your doctors here at Elgin Internal expanded their office hours to meet your needs. We have added evening hours and are opening up earlier in the morning as well. Please note that we are still your doctors. We will utilize the hospitalists only when you need inpatient hospital care. Upon your hospital discharge, your primary care physician here will resume your care.

We firmly believe this addition to our practice will enhance your medical care. Please feel free to further discuss this information with your personal physician.

Sincerely,  
Elgin Internal Medical Associates

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**PATIENT INFORMATION:**

**DATE:** \_\_\_\_\_

**LAST NAME:** \_\_\_\_\_ **FIRST:** \_\_\_\_\_ **MI:** \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_ **AGE:** \_\_\_\_\_ **M** \_\_\_\_\_ **F** \_\_\_\_\_ **CIRCLE ONE: M D W S**

**HOME ADDRESS:** \_\_\_\_\_  
NO: STREET CITY STATE ZIP

**HOME PHONE:** ( \_\_\_\_\_ ) \_\_\_\_\_ **CELL:** ( \_\_\_\_\_ ) \_\_\_\_\_

**SS#:** \_\_\_\_\_ **DL#:** \_\_\_\_\_ **E MAIL ADDRESS:** \_\_\_\_\_ @ \_\_\_\_\_

**EMPLOYER:** \_\_\_\_\_ **OCCUPATION:** \_\_\_\_\_ **PH#:** ( \_\_\_\_\_ ) \_\_\_\_\_

**EMPLOYER ADDRESS:** \_\_\_\_\_  
NO: STREET CITY STATE ZIP

**SPOUSAL INFORMATION IF APPLICABLE:**

**NAME:** \_\_\_\_\_ **SS#:** \_\_\_\_\_ **EMPLOYER:** \_\_\_\_\_

**EMPLOYER ADDRESS:** \_\_\_\_\_ **PH#:** ( \_\_\_\_\_ ) \_\_\_\_\_  
NO: STREET CITY STATE ZIP

**IN CASE OF EMERGENCY, PLEASE LIST NEAREST FRIEND OR RELATIVE NOT RESIDING WITH YOU:**

**NAME:** \_\_\_\_\_ **RELATION:** \_\_\_\_\_ **PH#:** ( \_\_\_\_\_ ) \_\_\_\_\_

**PRIMARY INSURANCE:**

**PLAN:** \_\_\_\_\_ **OWNER:** \_\_\_\_\_ **RELATIONSHIP:** \_\_\_\_\_

**BIRTH DATE OF OWNER:** \_\_\_\_\_ **COPAY AMOUNT:** \_\_\_\_\_

**SECONDARY INSURANCE:**

**PLAN:** \_\_\_\_\_ **OWNER:** \_\_\_\_\_ **RELATIONSHIP:** \_\_\_\_\_

**BIRTH DATE OF OWNER:** \_\_\_\_\_ **COPAY AMOUNT:** \_\_\_\_\_

**ANY OTHER INSURANCE INFORMATION:** \_\_\_\_\_

I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ANY INFORMATION TO MY INSURANCE COMPANY AND/OR FAMILY PHYSICIAN ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT. I HEREBY AUTHORIZE BENEFITS TO BE PAID DIRECTLY TO THEM. I UNDERSTAND THAT PAYMENT OF CHARGES IS NOT CONTINGENT UPON A SETTLEMENT FROM MY INSURANCE CARRIER, AND THAT I AM RESPONSIBLE FOR ANY UNPAID BALANCE. I WILL PAY ALL COLLECTION AGENCY'S AND/OR ATTORNEY'S FEES IF MY ACCOUNT BECOMES DELINQUENT AND NECESSITATES SUCH ACTION.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

(PATIENT OR GUARDIAN IF MINOR)

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745 FLETCHER DRIVE, SUITE 101  
ELGIN, ILLINOIS 60123  
TELEPHONE: 847-742-3525

## AUTHORIZATION to COMMUNICATE HEALTH INFORMATION

We often need to contact you with test results or answers to clinical questions. Please indicate your contact preferences below.

**Leave a message on my voice mail or answering machine.** My preferred message number is.

work .....

home.....

mobile .....

**You may leave a message with any other household member.**

**Speak only to me personally.**

Unless I answer, leave no message, only your phone number for me to call back. Do not leave a voice mail message or message with other household members. I am best reached at this number:

work .....

home.....

mobile .....

## AUTHORIZATION to DISCLOSE HEALTH INFORMATION

Family members may call to request your health information such as test results, or to discuss a diagnosis. This could include your spouse, parents, children, or significant others. Federal HIPAA rules require that we receive your permission before discussing your health information with anyone, including immediate family. Please indicate any limitations on communicating your health information below.

**You may discuss my health information with any member of my immediate family.**

**Discuss my health information only with the following person(s).**

.....  
name relationship

.....  
name relationship

.....  
name relationship

**Do not discuss my health information with anyone.**

## Receipt of HIPAA Privacy Policies

Federal HIPAA laws require us to provide our patients with a copy of our Patient Privacy Policies. Your signature below acknowledges your receipt of these policies today. It also confirms your contact and disclosure information, which may be revoked or modified at any time by completing a new form.

.....  
signature (patient or legal guardian) date

.....  
printed name (patient or legal guardian)

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**CONSENT FOR RELEASE AND USE OF CONFIDENTIAL INFORMATION  
AND RECEIPT OF NOTICE OF PRIVACY PRACTICES FORM**

I, \_\_\_\_\_, hereby give my consent to Elgin Internal  
(Name of Patient or Authorized Agent)

Medical Associates, S.C. to use or disclose, for the purpose of carrying out treatment, or health care operations, all information contained in the patient record of \_\_\_\_\_.  
(Patient's Name)

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available to a posting in the reception area of their office.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

If you are not the patient, please specify your relationship to the patient \_\_\_\_\_.

**OFFICE USE ONLY**

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices acknowledgement, but was unable to do so as documented below:

|       |           |         |
|-------|-----------|---------|
| Date: | Initials: | Reason: |
|-------|-----------|---------|

## ELGIN INTERNAL MEDICAL ASSOCIATES FINANCIAL POLICY FOR PATIENTS

We are dedicated to providing the best possible care and service to you and we want you to completely understand our financial policies.

1. Payment is due at the time of service unless arrangements have been made in advance by you or your insurance carrier. For your convenience, in addition to cash and personal checks for payment, we also accept VISA, MasterCard, Discover, and American Express.
2. Keep in mind that your insurance policy is basically a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to the doctor – in other words you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurance carrier, we will refund any overpayment to you.
3. We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill them on your behalf and you may be required (depending on your carrier), to pay a co-pay. We will collect all co-payments at the time of registration at the front desk.
4. If you have insurance coverage with a plan with which we do not have a prior arrangement, we will prepare and submit your claim on your behalf (out-of-network); however, your out-of-pocket expense may be greater.
5. We are **NOT HMO (HEALTH MAINTENANCE ORGANIZATION)** providers.
6. Not all insurance companies cover certain services. In the event your plan determines a service to be “not-covered”, you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. For services that we know or anticipate “non-coverage”, you will be asked to sign an ABN (Advanced Beneficiary Notice) at the time the service is provided.
7. For services provided in the hospital for inpatient services, your insurance will be billed by IPC, the Hospitalist Company. Our physicians do not make hospital rounds therefore these charges are billed by the physicians who see you in the hospital.
8. Patient statements are sent monthly. Payment is expected within 10 days of receipt. Payment options include, but are not limited to: payment plans and payments via credit cards as well as checks and cash. An account balance over 90 days will be assigned a service fee and forwarded to an outside Collection Service.
9. If collection efforts have failed, you will receive a Termination of Care Letter. Elgin Internal Medical Associates will provide ***Emergency*** care up to 30 days after the Termination of Care Letter is sent. You will need to locate a new physician at that point.
10. Without a 24 hour notice for cancellation of appointments patients will be charged a \$25.00 fee. In addition, if you fail to show up for an appointment, \$25.00 will also be charged to your account.
11. If at any time a check is returned for non-sufficient funds, a service fee will be assigned and your account will be forwarded to our outside Collection Service.

12. Please remember that nearly all issues of payment can be worked out through communication. *Please be sure you keep the Billing Department* aware of any payment issues. *That is your responsibility.*

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice. If any significant changes are made, I will be notified with an updated policy.

Signature of Patient or Responsible Party

If minor

Date

Print name of Patient

Revised 11/09

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

PATIENT NAME (Last Name, First Name, Middle Initial) MAIDEN NAME

ADDRESS CITY STATE ZIP

PHONE# BIRTHDATE

I, authorize (Name of Facility, Individual, Agency)

( ) To Release To:
( ) To Receive From: (Name of Health Care Facility, Individual, or Agency, etc)
(Address)
(City, State, Zip)

SPECIFIC INFORMATION TO BE RELEASED:

HOSPITAL RECORDS
Inpatient Date(s)
Outpatient Date(s)
Emergency Date(s)
Abstract Only (Discharge Summary, History & Physical, Operative Reports, Pathology reports, consults, EKGs, Radiology Reports, Laboratory Reports
Other

Office notes of: Date(s)
( ) Dr./Dept.
( ) Dr./Dept.
( ) Dr./Dept.
( ) Lab
( ) X-ray Reports
( ) EKG
( ) Immunization Record

\*The purpose of this disclosure of information is (i.e. continuing care, insurance claim, etc.)

\*I understand that my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health service, developmental disabilities, or treatment for alcohol and/or drug abuse.

\*I have the right to inspect and obtain a copy of the records that are to be disclosed (CFR 164.524). I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I may contact the Privacy Manager for questions regarding disclosure of my health information.

\*I understand that my refusal to consent to the above mentioned information will prevent the disclosure of the information. I understand that if this authorization is for the purpose of third party payment, that medical information as may be necessary to process benefits will be disclosed to my insurance company and/or insurance company's review agency. If I refuse to authorize release of information for this purpose, it may adversely affect my entitlement to insurance benefits.

\*I understand that I may revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Privacy Officer. I understand the revocation will not apply to information that has already been released in response to this authorization.

\*This authorization will not expire unless I state specifically that it is intended for a specific length of time or for a specific event.

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Signature of Patient or Representatives

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Date

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If signed by other than patient; state relationship

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Witness

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Date

