PATIENT INFORMATION

Patient's Name: _____ Date: _____

Email: _____ Social Security #: _____-_____-_____

How did you hear about Dr. Tresley?

- ☐ Internet
- ☐ Physician Referral
- ☐ Friend Referral
- ☐ Facebook
- ☐ Instagram
- ☐ Other

GUARANTOR INFORMATION:

(The guarantor is the responsible party for insurance payments and charges.)

Check here, if same as patient above

Guarantor's Name: _____

Relationship to patient: _____

Home Address: _____ City: _____

State: _____ Zip: _____

Phone: (C)_____ (H)_____

INSURANCE POLICY:

Patients with Private Healthcare Insurance:

The private healthcare insurance presented at the time of your visit will be billed for your treatment, HMO patients will need to start the process of securing a referral. Every effort will be made to ensure that claims are promptly and correctly submitted to your insurance company. Your insurance company has 30 days after receiving a correctly filed claim to process, pay and/or give notice as to why the claim has not been paid. After that time the remaining balance will be your responsibility. If you are not satisfied with the payment made by your insurance company, contact them directly at the phone number listed on your insurance card. If you chose to appeal to your insurance company in writing for additional payment please provide Daniel S. Tresley, M.D. with a copy of that appeal for your file.

_____ INITIAL

Patients with Worker's Compensation or Automobile Accident Insurance:

If your injury was received as a result of a motor vehicle accident or a liability and you do have private healthcare insurance, typically your private healthcare insurance will not make payments on your medical claims without a written denial from your motor vehicle insurance/liability insurance. It is very important that all pertinent information be given at the time of your visit regarding the motor vehicle insurance/liability insurance, including claim number, agent information, claim billing address, accident report, etc.

Name of Insurance Company: _____

Phone Number:_____

Address: _____ City:_____

State:_____ Zip: _____

Case/Claim #: _____Date of Injury: _____

Patients with Illinois Department of Public Aid-IDPA (MEDICAID):
IDPA is not accepted at Daniel S. Tresley, MD. Full payment or an approved payment plan is expected at the time of service.

_____Patient initials

Patients without Private Healthcare Insurance – Self Pay:
If not private healthcare insurance is presented at the time of your visits, full payment or an approved payment plan is expected at the time of service.

_____Patient initials

FOR ALL PATIENTS:

- Any insurance policy is a contract between you and your insurance company.
- It is your responsibility to verify, with your insurance company, if a provider is in or out of network for your plan.

  _____Patient initials
- Any unpaid balance left by your insurance company will be your responsibility.

  _____Patient initials
- Insurance benefits paid directly to the patient will need to be forwarded to Daniel S. Tresley, MD to keep the account in good standing.
- If you have retained an attorney regarding your injury, it is very important to provide Daniel S. Tresley, MD with that information.
- Payment plans can be established with the approval of the billing department 847-770-6660.
- Cash, checks ,Visa or MasterCard are accepted for payment.
- You can contact the billing department with any questions.

EMERGENCY CONTACT INFORMATION:

Emergency Contact: _____ Relationship to patient: _____

Phone (cell):_____

Please list names of people we can discuss your medical or cosmetic care with RELATIONSHIP*

Spouse Name: _____ _____

Parent Name: _____ _____

Other Name: _____ _____

*For "Other" please give name and relationship such as boyfriend, sister, parent etc.

CREDIT CARD PAYMENT SYSTEM:
In order to facilitate our billing process, Daniel S. Tresley, MD has implemented a Credit Card payment system. Our goal is to assist our patients in eliminating past due patient accounts. Your credit card information will be held securely on file until your Insurance Company has paid your claim. Once your "Explanation of Benefits" has been filed, any remaining balance owed by you "patient responsibility", will be charged to the credit /debit card we have on file. A copy or receipt of those charges will then be mailed to you. The advantage to you is that you will no longer need to write out checks and send payments in mail. You will also not have to worry about any past due accounts. This in no way will compromise your ability to dispute charges or question your insurance company's determination of payment. All credit card contracts give card holders the right to challenge any charges against an account.

Name on Card _____

Patient's Name(if different than cardholder) _____

Cardholder Signature _____

Our goal is to provide you with the highest quality of care while keeping the cost of medical care low.
Card will be swiped, encrypted and securely saved on file for your convenience

CONSENT TO PHOTOGRAPHS:

I, _____ (print full name) understand that photographs will be taken periodically throughout my treatments. These photographs will be used to monitor progress and other factors. I consent to the taking of photographs by Dr. Tresley, or his assistant of me in connection with the procedure(s) to be performed by Dr.Tresley. I grant Dr. Tresley the right to use photographs of me, in the following areas:

- ☐ All
- ☐ Website for Consumers
- ☐ Newsletters or emails to be sent to patients
- ☐ Practice Brochures
- ☐ Public relations materials
- ☐ Seminars
- ☐ Patient Before & After information sheets
- ☐ Social Media
- ☐ Chart Only, not for use in advertising material

If in the judgment of my physician, medical research, education or science will benefit by their use, the photographs and information relating to my case maybe published and republished in professional journals and medical books, or used for any other purpose which he may deem proper in the interest of medical education, knowledge, or research. I understand that in any such publication or use I shall not be identified by name. I understand that I may refuse to authorize the release of any photo documentation and that my refusal to consent to the release of photo documentation will prevent the disclosure of such information, but will not affect the healthcare services I presently receive, or will receive. I understand that by signing below that Dr. Daniel Tresley need not approach me again for authorization on these photos.

Patient's Signature: _____ Date: _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM HIPAA:

I, _____have been informed that a copy of our office's Notice of Privacy Practices is available upon request. HIPAA is an acronym for the Health Insurance Portability & Accountability Act of 1996 (a federal law). Of significant concern to healthcare organizations is the Administrative Simplification section of the Act, which requires healthcare organizations to comply with specific rules regarding:

- Unique Identifiers for health plans, providers, individuals, employers
- Healthcare Transaction & Code Sets for transmitting data electronically
- Privacy regulations over disclosure and use of health information
- Security regulations over protections of electronic health information

It is our policy to not release confidential and/or unauthorized information except appointment confirmation by home telephone, answering machine, work telephone, voicemail, and cell phone. Information will also not be left with an unauthorized person who may answer the telephone. If you would like to have information released to someone other than yourself please complete the following:

I authorize the doctor's office to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them, in writing, whenever this information changes.

Home phone: ☐ YES ☐NO
Cell phone: ☐ YES ☐NO
May we fax medical records for referral? ☐ YES ☐NO

I hereby authorize Daniel S. Tresley, MD to obtain or release any and all pertinent information regarding my medical care, as needed, to assist in my ongoing treatment to or from other healthcare providers, laboratories, radiology facilities or other institutions. This authorization remains in effect until revoked.

Patient Signature: _____