Center for Headache Medicine

www.HeadacheMedicine.Info 630.719.0900

Welcome to our practice! We are glad that you chose us. Please take a few moments to fill out and sign the form below and the next two pages. These forms must be signed to see the doctor. If you have any questions please ask, we would be glad to explain any confusing part of this form. Thank you.

PERSONAL INFORMATION

Last Name	First Name	M	Sex	Social Security #
			M/F	

Street	City	State	Zip Code	Date of Birth

Home Phone #	Cell Phone #	Work #	Referring Dr.
(____)_____	(____)_____	(____)_____	_____

Emergency Contact	Emergency Contact #	Relationship	Marital Status
_____	(_____)_____	_____	S/M/D/ Other

INSURANCE INFORMATION

Primary Insurance _____ Co-Pay Amt: _____

Is this your insurance? Yes/No

If no, Insurance Name	Employer	Insurance holder's Birthdate
_____	_____	_____

Secondary Insurance _____ Co-Pay Amt: _____

Is this your insurance? Yes/No

If no, Insurance Name	Employer	Insurance holder's Birthdate
_____	_____	_____

Is this visit due to symptoms from and auto accident or injury at work? Yes/No

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Congress has reduced payments to physicians for Medicare patients since 2006. With the current Medical plan outlined, physician's payments are scheduled to be reduced by another 30% effective January 2012.

Since reimbursements continue to fall and the costs to practice medicine rises, we either need to reduce the quality of service or reduce costs associated with quality care. We do not want to reduce quality of service. Since January 2006 we have implemented a policy to help reduce costs by requiring all patients to have a signed credit card authorization on file that will be used to pay for deductibles, co pays and non-insurance covered services (such as prior drug authorizations, missed appointments, duplicate medications or disability forms). By signing below you authorize us to bill any insurance determined deductibles and co pays (as per your Explanation of Benefits) and any non-insurance covered services of $50.00 or less without sending you a separate bill. There are no exceptions to this policy. If you will not or cannot comply with this policy, we will facilitate your transfer to another doctor's care and will continue as your physician for the next 30 days.

We are sorry for any inconvenience this may cause you. If you do accept this policy by signing below but do not keep an updated copy of your credit card on file with us, it will be assumed you are no longer in agreement with this policy. At that time, we will send you a 15-day notice of our intention to terminate care unless you provide a valid credit card within 15 days. By signing below, you also agree that this is adequate notice to terminate doctor patient relationship.

If you are a Medicare patient (or have parents that are Medicare patients) please contact your congressman and women to express your opinion about these reimbursement reductions. Our office will supply you with a list of Illinois congressman and women email and phone numbers upon your request.

PLEASE PRINT YOUR NAME AND SIGN BELOW:

NAME: _____

I accept the above credit card policy: _____ Date: _____

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I certify that to the best of my knowledge the information provided is correct. This signature on file is my authorization for the release of any information necessary to process my insurance claim and to any doctor designated by me as actively involved in my medical care. If an insurance claim is filed at my request, I authorize payment to the medical practice of David S. Larsen M.D. benefits otherwise payable to me for the services that I received by this medical practice.

Signature _____ Date _____

By signing the form below you are stating that you understand and agree to the following:

1. **The Financial Policy** of this practice is that we provide a service to you at your request and you are responsible to reimburse us for that service at the time of service at the amount that you are billed. These amounts are not arbitrarily determined but are in line with Neurological care provided in this zip code as published by an independent data service. An estimate will be provided either now or at the time of the appointment. The only exception to you paying us at our billed amounts is if we have a contract with your insurer and/or have agreed to a different amount before your visit. We accept Medicare assignment and are also in several PPO and POS plans. If we are not in your insurance plan network, you will be responsible for a larger portion of the bill. Again, we will be glad to provide an estimate of this additional amount.
2. **Payment is due at time of service.** Cash, credit cards and checks are accepted as payment. As a service to our patients we will process your insurance claim or referral to your insurance company. We will make every effort to collect your medical bill from your insurance company for sixty days from the visit date. After that time by signing the below you authorize us to apply the balance of your bill at our discretion to your credit card on file.
3. **Pay your balances on time.** If you receive billing information from your insurance plan regarding the amount you are responsible for, please pay this amount and do not wait for a statement from us. Should we not receive your payment, we will apply your balance to your credit card. Call if you have any questions regarding the amount to pay.
4. **Fee for cancelled appointments.** In consideration of all our patients, there is a fee for canceling appointments without ***one business day notice.*** (NOTE: Our office is closed on Wednesday, Saturday and Sunday. These days are NOT considered business days)

In the event I fail to pay the balance of my account to David S. Larsen M.D., I hereby agree that David S. Larsen M.D. upon sending my account to a collection agency, I will be responsible to pay the fee charged by the collection agency to David S. Larsen M.D.

5. **Acknowledgement of Privacy Practices.** Upon request, a copy of David S. Larsen M.D. notice of privacy practices will be provided. The notice contains information regarding potential uses and disclosures of my protected health information (as that term is defined under Health Insurance Portability and Accountability Act of 1996 HIPPA) that may be made by the practice, and of my rights and the practice's legal duties with respect to my protected health information.

Signature_____ Date_____