Mid Illini Surgical Associates, SC

Patient Name (first, middle, last)	Social Security No.	Male / Female
Address	City/State/Zip	Date of Birth

Home Phone (w/area code)	Cell Phone (w/area code)	Work Phone (w/area code)

How did you find out about our practice: [] Newspaper [] TV [] Radio []Internet [] My Family doctor [] Other

Email Address:

Patient's Employer	Employer Address / City / State / Zip

Legal Next of Kin	Relationship	Address /City / State / Zip	Phone (w/area code)

Friend or Relative Not Living with You	Relationship	Phone (w/area code)

Primary Care Physician (PCP) Referring Physician	City

Primary Insurance Information

Insurance Company Name

Policy Holder's SS#	Group #	Policy #

Policy Holder's Name (first, middle, last)	Relationship to Patient & Date of Birth
Policy Holder's Address (if different than patient)	City / State / Zip

Secondary Insurance Information

Insurance Company Name

Policy Holder's SS#	Group #	Policy #

Policy Holder's Name (first, middle, last)	Relationship to Patient & Date of Birth
Policy Holder's Address (if different than patient)	City / State / Zip

CONSENT FOR RELEASE OF INFORMATION: It is our desire at Mid Illini Surgical Associates to protect patient confidentiality as well as provide excellent medical care. Therefore, if you would like us to discuss your medical care and treatment with anyone other than yourself, we request your signed written consent.

I hereby consent that Mid Illini Surgical Associates staff may discuss my health care and treatment with the following individuals:

Name	Relationship
1.	
2.	

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance and other health plans to Mid Illini Surgical Associates. Obtaining required referral forms and treatment pre-certification is my responsibility. I understand that I am financially responsible for all charges whether or not paid by an insurance or health plan. A photocopy of this assignment is to be considered as valid as the original. If I do not provide evidence of insurance all charges will be my responsibility and payable at the time of service. All unpaid balances or denied claims are my responsibility. I hereby authorize said assignee to release all information necessary to secure payment. If collection is required, patient shall be liable for all costs of collections including collection agency fees (collection agency fees are typically 33% to 50% of unpaid balance), attorney fees, and court costs.

Signature of patient (parent if minor)	**Date**

Atrium Building
900 Main Street, Suite 530
Peoria, IL 61602
ph: (309) 672.5975
fax: (309) 655.1678
www.misateam.com

MISA

MID ILLINI SURGICAL ASSOCIATES
Your Comprehensive Surgical Team.™

Consent for Release and Use of Confidential Information And Receipt of Notice of Privacy Practices Form

I, _____, herby give my consent to **Mid Illini Surgical Associates, SC** to use or disclose, for the purpose of carrying out treatment, payment or healthcare operations, all information contained in the patient record of _____.

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 by US Mail or be made available at my next visit.

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 relied on it to 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

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Insurance Benefit & Coverage Form

Instructions: Complete this form & bring to your appointment

If you do not know the terms of your insurance, it is your responsibility to ***call your insurance company and obtain the information.***

Notice: If elective surgery is recommended, but your deductible for the current plan year is not met, you may be required to pay a portion of your deductible PRIOR to your procedure.

- **Name of Patient:** _____
- **Name of Policy Holder** (subscriber):_____
  (if different than patient)
- **Insurance Company Name:**_____

Co-Pay Amount for **Specialist Office** Visit:_____

Yearly Deductible Amount:_____

Deductible Amount Remaining:_____
(this is the amount still owed)

Deductible Amount Met:_____
(this is the amount already paid)

Hospital(s) Allowed By Your Insurance to Use:_____
_____