MUNOZ MD & CVENGROS MD, SC
2800 N Sheridan Road Suite G2
Chicago, IL 60657
Office: 773 755 2600
Fax: 773 880 0403

Today's date	Referred By: ❑ Insurance ❑ Hospital ❑ Family/Friend ❑ Website ❑ Other_____ ❑ Dr.

PATIENT INFORMATION

Patient's First Name	Middle Name	Last Name	❑ Mr ❑ Mrs ❑ Dr ❑ Miss ❑ Ms
Address		City State Zip	
Cell Phone	Home Phone	Work Phone	
Occupation	Employer	Email Address (Used only for e-statements & appt. reminders)	
Date of Birth (mm/dd/yyyy)	Sex ❑ F ❑ M	Social Security Number (Used only for billing to your insurance)	Marital Status ❑ Sng/❑ Mar/❑ Div/❑ Sep/❑Wid

INSURANCE INFORMATION (PLEASE HAVE YOUR INSURANCE CARD OUT FOR US)

Name of Insurance	Group Number	Policy Number	Subscriber's Name
Secondary Insurance (if applicable)	Group Number	Policy Number	Subscriber's Name

RESPONSIBLE PARTY / GUARANTOR / PARENT (IF SAME AS ABOVE, ❑ CHECK HERE & SKIP)

First Name	Last Name	Date of Birth	Social Security Number
Relationship to Patient	Address		
Home Phone	Cell Phone	Work Phone	

EMERGENCY CONTACT

Name	Relationship	Cell Phone	Home Phone	Work Phone

I authorize release of all information, including diagnosis and treatment records for me or my child, as determined to be necessary to receive payment from an insurance or other payer, or in connection with my care, to another health care provider. I authorize and request that my insurance company or government payer pay directly to **Munoz M.D. & Cvengros M.D., S.C.** I agree to be responsible for payment for all services rendered to me or my dependents, including amounts not paid by my insurance company or other responsible payer.

PATIENT OR GUARDIAN SIGNATURE ***Today's Date***

Financial Arrangements: Payment in full is expected at each appointment. For your convenience we accept Cash / Check / Visa / Mastercard / AMEX

REQUEST FOR CONFIDENTIAL COMMUNICATION

I _____, hereby request **Munoz M.D. & Cvengros M.D., S.C.** to
Name of Patient
keep communications regarding my protected health information confidential. To accomplish this request please adhere to the follow requests:

Phone	You can contact me by phone at	Leave a message on answering machine / voicemail ❑ Yes ❑ No Leave a message with any other person ❑ Yes ❑ No
Text / SMS	❑ Please do not contact me by Text / SMS ❑ Please contact me by Text / SMS at	
Email	❑ Please do not contact me by EMAIL ❑ Please contact me by EMAIL at	

This request may be changed or revoked by filing a new request or revoking this one in writing.

Patient signature ***Date***

CANCELLATION POLICY

Kindly give **24 hour notice** if you are unable to keep your scheduled appointment at 773-755-2600.

If you fail to show for an appointment without contacting our office, a $25 charge will apply, which cannot be billed to your insurance carrier. Thank you for your attention to this matter.

I have read and understand the cancellation policy for **Munoz M.D. & Cvengros M.D., S.C.**

Patient Name ***Patient Signature*** ***Date***

HIPPA PRIVACY POLICY

I am aware of the HIPPA Privacy Policy of **Munoz M.D. & Cvengros M.D., S.C.**

Patient signature ***Date***

Chicago Med Group

We are dedicated to providing the best possible care for you, and we want you to understand our financial policies to avoid any future misunderstandings.

INSURANCE

As a courtesy, Chicago Med Group, verifies your benefits with your insurance company.
We do this so that you:

- Will have an estimate of what your financial responsibility will be,
- and to determine what portion of your charges should be paid by you at or before the time of service.

A quote of benefits is not a guarantee of benefits or payment. Your claim will process according to your plan, if your claim processes differently from the benefits we were quoted, the insurance company will side with the plan and will not honor the benefit quote we received. We cannot guarantee what your insurance company will pay. Therefore, you may receive a bill from us if the insurance company denies, changes, or reduces the payment for the services we provided. Benefit verification is an estimate, not a guarantee of your insurance benefits. You are financially responsible for all charges unless a contract between us and your insurance company prohibits us from billing you. As a service to you we will file your insurance claim if you assign the benefits to us so that your insurance company can pay us directly. We will also follow up for you, but if your insurance company does not pay the claim within a reasonable period, we will have to look to you for payment.

SELF - PAY

If you do not have insurance, or if we cannot verify your coverage, payment is due at the time of service.

We offer discounted pricing for self-pay visits and convenient payment plans.

CO-PAYS / DEDUCTIBLES / CO-INSURANCES

All co-payments, deductibles, and co-insurances must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

If your insurance plan has a deductible you have not yet met (we will verify your coverage at the time of visit) you will be expected to pay the visit in full. We offer convenient payment plans.

CREDIT CARD POLICY

INITIAL _____

It is the policy of this office to keep a credit card on file. This is a convenient method of payment for the portion of services that your insurance does not cover, but for which you are liable. Furthermore, most insurance plans require deductibles and copayments that may not be known to you or us at the time of your visit.

Your credit card will only be used to pay account balances after insurance processing and/or:

- You instruct us to bill your credit card for any outstanding balance.
- Your balance is 60 days past due and we have sent you at least 2 statements. _____
- Your insurance card is invalid and you do not have additional insurance.

The following patients are exempt from having a credit card on file:

- Self-Pay patients will not be required to place a credit card on file.
- Patients with active Medicaid will not be required to place a credit card on file.

RETURNED CHECKS

We will charge a fee of $35.00 for all checks returned unpaid.

MISSED APPOINTMENTS

We request a 24-hour notice for cancellations. $25.00 will be charged for all missed appointments without a 24-hour notice.

CREDIT CARDS ACCEPTED

We accept Visa, MasterCard Discover and AMEX.

COLLECTIONS

If your account is delinquent, we may file it with a collection agency to collect payment. If this becomes necessary, your account may be charged additional fees to offset some of the collection costs we incur. Any account with an unpaid balance that is determined to be your responsibility by the insurance company may be sent to collections after 3 statements.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

_____

Signature of patient (or responsible party, if minor)

_____

Please print the name of the patient Date

Chicago Med Group

Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurance, and the insurance portion of the claim has paid and posted to the account.

I authorize Chicago Med Group to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

☐ AMEX ☐ VISA ☐ MASTERCARD ☐ DISCOVER

Credit Card Number:	**Expiration Date (mm/dd/yyyy)**
	Security Code:
Cardholder Name:	**Signature**
Billing Address and Phone Number:	

I (we), the undersigned, authorize and request **Chicago Med Group** to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility. This authorization relates to all payments not covered by my insurance company for services provided to me by **Chicago Med Group**. This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notification to **Chicago Med Group** in writing and the account must be in good standing.

Patient Name (Print): _____

Patient Signature: _____ Date: _____ / _____ / _____