WELCOME TO OUR PRACTICE!

Please take a few minutes to answer the following questions so we can better assist you with your health care needs. Thank you!

PATIENT INFORMATION

Name:____

Last First Middle Initial

Birthdate: _____/_____/_____ Sex: M ( ) F ( ) Home Phone: ( )___________________________

Address: ____

City: __________________State: ________ Zip: __________ Cell Phone: ( ) ___________________

In Case of Emergency, who should we contact? Name: ____

Relationship to Patient: _________________________ Phone #: ( )___________________________

Preferred Pharmacy Name and Address: ____

LEGAL GUARDIAN INFORMATION

Name of Legal Guardian 1: __________________________ Occupation: __________________________

Name of Legal Guardian 2: __________________________ Occupation: __________________________

Email Address for Online Portal Access: ____

PRIMARY INSURANCE

Person Responsible for payment of account: ____

Relationship to Patient: ____ Birthdate: _____/_____/_____

Social Security #: ______________________________ Phone #: ( )___________________________

SECONDARY INSURANCE

Person Responsible for payment of account: ____

Relationship to Patient: ____ Birthdate: _____/_____/_____

Social Security #: ______________________________ Phone #: ( )___________________________

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to Dr. Nava Segall for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize Dr. Nava Segall to release the information required to secure the payment of benefits. I authorize this signature on all insurance submissions.

Signature of Responsible Party: ____________________________________ Date: ___________________

Nava Segall M.D.

4116 N. Lincoln Ave. Chicago IL 60618 – 773 8832350

BILLING FREQUENTLY ASKED QUESTIONS

1: I am now receiving bills for services that were previously covered by my insurance. Why has the Pediatrics Office changed its billing practice?

The Pediatrics Office has not changed its billing practices in any substantial way for many years. What has changed is your insurance coverage. When you enroll in a health insurance plan, you are signing a contract that dictates whether specific health care charges are the responsibility of you or the insurer. We at Nava Segall, M.D. Pediatrics have no control over the specifics of this contract.

2: My child was seen for a well-child checkup. Why was I also billed for a sick visit?

Our contracts with health insurers dictate a certain level of payment for well-child checkups. Well-child checkups include an assessment of growth and development, a screen for medical and psychological problems, anticipatory guidance to aid parents in the next steps of their child's development, a review of the child's vaccination status and updates as needed, and the generation of a "health form" that clears children for participation in school, sports, and camp activities. In the course of performing a well-child checkup, your physician will be happy to address any specific concerns or questions that you have about your child's well-being. Many of these are simple questions that can be addressed quickly and clearly fall within the scope of a regular checkup.

In some instances, a more significant health problem will be identified at the well-child visit, or a chronic medical issue will be discussed. If so, the time and effort your physician spends addressing these health problems go beyond the scope of what is covered as part of a well-child visit. Some examples of such scenarios include:

(1) The recognition of a new medical problem.
(2) A discussion of a chronic medical issue.

When these scenarios arise, your physician will generate a billing code for well-child visits treated at the same visit. This is standard billing practice among all primary care providers (pediatricians, internists, and family practitioners). Modifier codes are accepted as standard practice by government agencies and by private health insurers.

In the past, many health insurance plans covered these "modifier" billing codes in full. As insurance coverage has evolved, however, an increasing number of patients are now being asked to pay either the full cost of these modifiers billing codes or a co-pay for the modifier portion of the total visit.

Again, our billing practices have not changed, nor has our contract with the insurers in this matter. What has changed for many of you is the contract you have signed with your insurer.

3: I understood that I had no copay for well visits. Why was I charged a copay for my child's recent visit?

As per question #2 above, this scenario usually occurs when the patient was billed not only for a well visit but also for a simultaneous sick visit using a "modifier" code. Your insurance coverage may dictate that you are

responsible for the co-pay for the sick visit portion of the bill. It is not our decision to charge you a co-pay. Your copay results from your contract with the insurer.

4: Why am I being charged a $25 no show fee?

In order to provide the same comprehensive, professional and compassionate care we have made changes in our appointment policy starting January 1, 2015. We realize that unexpected events can happen, but in order to see patients in a timely manner and be able to accommodate those needing urgent appointments we have put a no show fee in place. We are requiring 24 hours notice for any changes or cancellations to appointments. Any changes or cancellations within the 24 hour period will incur a $25 no show fee and will be due prior to entering the next appointment.

Name: ____________________________

Signature: _________________________

Date:_____________________________

NAVA SEGALL ACKNOWLEDGEMENT

I hereby acknowledge receipt of the Notice of Privacy Practices.

Patient's Name: __________________________ Date of Birth: _____________

Patient's Signature: ______________________ S.S.N.: __________________

Date: ______________

If this acknowledgement is by someone other than the patient (a personal representative) please complete the following:

- **A personal representative is a person legally authorized to act on behalf of an individual for health care decisions, including, in most cases, a parent of a court appointed guardian, executor or administrator.**

Personal Representative's Name:

Personal Representative's Signature: ______________________

Relationship to Patient: ______________________

If unable to obtain written acknowledgment of receipt of the Notice of Privacy Practices, document good faith efforts to obtain acknowledgment and the reason why the acknowledgment was obtained below.

____

____

____

Signature of Practice's Workforce Member:

____

Print Name: ____

Date:

____

Nava Segall M.D
4116 N. Lincoln Ave.

Chicago, IL 60618

773-883-2350

Well Care Verification

By providing us with the following information you will be assisting us in the best immunization program for your financial needs.

Please provide us with the following

Insurance Company Name ____

Child/Children Name ____

Does your insurance cover well checks? YES or NO

Does your insurance cover immunizations? Yes or NO

Do you have a deductible? Yes or No $ ___________________ deductible amount

Does your well care have a dollar amount maximum per year on well care? Yes or No

If so, how much? _________________________

It is your responsibility to inform us if any of the above information changes. We will have you initial at every care visit to verify the information prior to giving immunizations in the event the information given is incorrect and there is a balance at your well care visit we may have you reschedule your appointment until the balance is resolved.

Any well care given by VFC will be payable at each time of service.

Please keep in mind that the Chicago Department of Public Health is an option for immunizations if you have no insurance coverage for vaccines.

Please sign and date ____

Patient Name: ____
Address: ____
Phone Number: ____
Date of Birth: ____

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

I hereby authorize that the protected health information regarding the above-named person be forwarded:

FROM: **Person/Institution:** ____
Address____
City: ___________**State:** ____**Zip Code:** ________ **Phone:** _____________**Fax:** _____________

TO: Person/Institution: **Nava Segall**
Address **4116 N. Lincoln**
City **Chicago** State **IL** Zip Code **60618** Phone: **773-883-2350** Fax: **773-883-2351**

Purpose or need of information: ____

What is being authorized for release?
Please check and initial the specific protected health information you are authorizing be used and/or disclosed (if this authorization is for psychotherapy notes, no other type of protected health information may be listed on this authorization).

- ☐ General Medical Initial_____________
- ☐ Mental Health Initial ____________
- ☐ Alcohol/Substance Abuse Initial _____________
- ☐ Genetic Testing Initial ______________
- ☐ HIV/AIDS Initial _______________
- ☐ Physician Name/Dept. of Service Initial _______________

Other (Please specify):____

I must check one of more of the following types of health information that I do not want released to the above named recipient. I understand that if I do not check any of the three (3) following boxes, the health information released to the named Recipient may include any of the following:

☐ Diagnosis, Evaluation and/or treatment for alcohol and/or drug abuse

☐ Records of HTLV-III or HIV testing (AIDS test) result, diagnosis and/or treatment

☐ Psychiatric, psychological records of evaluation and/or treatment for mental, physical and/or emotional illness including narrative summary, test, social work assessment, medication, psychiatric examination, progress notes, consultations, treatment plans. And/or evaluation.

I also understand that this Authorization is subject to revocation/withdrawal by me at any time in writing to the medical record contact at this site of care except to the extent that action has already been taken to release this information. This authorization shall remain valid unless revoked by will expire in 1 year after signing. I have a right to inspect a copy of the health information to be released and if I do not sign this Authorization, the institution named above will not release my health information. The above named person/institution will not refuse to treat me based on whether I agree to allow my health information to be used and disclosed to others.

_____________________________________ ___________________________
Signature of Patient **Date**

_______________________________________ ____________________________
Signature of Parent/Legal Guardian/personal Representative **Relationship to Patient**
(Required if Patient is not legally authorized to sign Authorization)

REDISCLOSURE:Notice is hereby given to the patient or legal representative signing this Authorization that Nava Segall M.D.S.C. cannot guarantee that the recipient receiving the requested health information will not redisclose any or all of it to others. Notice is hereby given to the Recipient that prohibits the redisclosure of any health information regarding drug and/or alcohol abuse, HIV and mental health treatment.