Nihon Clinic
日本クリニック

## PATIENT INFORMATION 外来診察申込書

DATE: _____ 紹介者： _____
REFERRED BY:

患者氏名
FIRST NAME: LAST NAME:

誕生日 月 日 年 年齢 性別 男 女 独身 既婚 ソーシャルセキュリティー
D.O.B. / / AGE: SEX: M F ☐ Single ☐ Married SSN:

世帯主名 ☐ 同上(same as above) 勤務先
GUARANTOR: EMPLOYER:

自宅住所 勤務先住所
ADD: ADD:

CITY: ST: ZIP: CITY: ST: ZIP:

自宅電話 勤務先電話
TEL: ( ) TEL: ( )

携帯電話 ファクシミリ
CELL: ( ) (Father /Mother) FAX: ( )

E-MAIL: E-MAIL:

## INSURANCE INFORMATION 医療保険

保険会社
COMPANY: POLICY#: GROUP#:

保険会社住所 電話
COMPANY ADD: TEL:

被保険者氏名 ☐ 同上 (same as above) ソーシャルセキュリティー
FIRST NAME: LAST NAME: SSN:

誕生日 月 日 年 年齢 性別 男 女 被保険者との関係 自身 夫婦 子供 他
D.O.B. / / AGE: SEX: M F RELATION TO SUBSCRIBER: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

被保険者住所 ☐ 同上 (same as above)
SUBSCRIBER ADD:

CITY: ST: ZIP:

## EMERGENCY CONTACT 緊急時の連絡先

緊急時連絡先 患者との関係 自身 夫婦 子供 他
CONTACT PERSON: RELATION TO PATIENT: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

連絡者住所 自宅電話
HOME ADD: HOME TEL: ( )

日本での連絡先住所: 電話番号
( )

**AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS**

I hereby authorize to release any information in the course of my treatment or examination to my insurance carrier.
I hereby authorize payment to Physician of Benefits due me for service rendered. I understand that I am responsible for charges not covered by this authorization.

SIGNED: DATE:

## ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

*For office use only:*

Patient Name: _____
Medical Record #: _____
Date of Admission: _____

By signing this form, you acknowledge that Nihon Clinic has a Privacy Policy in place in accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The policy, which has been made available for my review, explains how your health information will be handled in various situations. You must sign this form on your first date of service with us after December 1, 2014.

If your first date of service with us was due to an emergency, we must try to give you this notice and get your signature acknowledging receipt of this notice as soon as we can after the emergency.

Check all that are true:

[ ] I have reviewed Nihon Clinic's Privacy Notice.

[ ] I understand that I am entitled to a copy of this Privacy Policy if I so choose.

[ ] Nihon Clinic has given me the chance to discuss my concerns and questions about the privacy of my health information.

_____ _____
Patient's Signature Date

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To be completed by Nihon Clinic's staff if Acknowledgement Form is not signed:

Does patient have a copy of the Privacy Notice?

[ ] Yes [ ] No

Please explain why the patient was unable to sign an acknowledgement form and Nihon Clinic's efforts in trying to obtain the patient's signature:

_____

_____

_____

NIHON MEDICAL CLINIC
2010 S Arlington Heights Road, Suite 101, Arlington Heights, IL 60005

# Financial Agreement

We, the staff of ***Nihon Medical Clinic*** thank you for choosing us as your health provider. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with the highest level of care and to building a successful provider-patient relationship with you and your family. We believe your understanding of our patients' financial responsibility is vital to that provider-patient relationship and our goal is to not only inform you of the provisional aspects of the financial policy but also to keep the lines of communication open regarding them, If at any time you have any questions or concerns regarding our fees, policies, or responsibilities please feel free to contact our front desk staff at ***847-9528910***.

We believe this level of communication and cooperation will allow us to continue to provide quality service to all of our valued patients.

Please understand that payment for services is an important part of the provider-patient relationship. If you do not have insurance, proof of insurance, or participate in a plan that will not honor an assignment of insurance benefits, payment for services will be due at the time of service unless a payment arrangements has been approved in advance by our staff.

We make payment as convenient as possible by accepting cash, in-state check, money order, Visa and MasterCard. A $35.00 service fee will be charged for all returned checks. Additionally, you may authorize us to keep your credit card on file for your convenience knowing that we adhere to the highest level of information security.

**Interest**

Interest will incur if a balance remains unpaid after 60 days.

**Insurance**

Please remember that your insurance policy is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefit under your policy. We have found that patients who are involved with their claims process are more successful at receiving prompt and accurate payment services from their insurance carrier. We do expect patients to be interactive and responsible for communicating with your insurance carrier on any open claims.

It is your responsibility to provide all necessary insurance eligibility, identification, authorization and referral information and to notify our office of any information change when they occur. Even a preauthorization of services does not guarantee payment from your insurance carrier. We also require photo identification when accepting insurance information. It is the patient's responsibility to know if our office is participating or non-participating with their insurance plan. Failure to provide all information may necessitate patient payment for all charges. When insurance is involved, we are contractually obligated to collect co-payment, co-insurance, and deductibles, as outlined by your insurance carrier.

Please be aware that out-of-network insurance carries often prohibit assignment of benefits and may try to limit their financial liability with arbitrary limits, exclusions, or reductions such as reasonable and customary or usual and prevailing reductions. Our fees are well within such ranges and although we will assist in the filing or an appeal if these limitations are imposed, you as the guarantor are responsible for all out-of-network fees. If we are not contracted with your carrier we will not negotiate reduced fees with your carrier.

**Miscellaneous Forms, Additional Information and Authorization**

We will provide all necessary information to have your benefits released. However, if it becomes necessary to submit redundant or unnecessary information for the completion of claim forms for school, sports, or extra-curricular activities there will be an administrative fee, not to exceed $35.00, for the additional information.

**Missed Appointments**

We require notice of cancellation 24 hours in advance. This allows us to offer the appointment to another patient. If you fail to keep your appointment without notifying us in advance: a missed appointment fee will apply. These fees are typically $35.00 but not to exceed one-half of the cost of your scheduled appointment. Repeated missed appointments without notification many cause you to be discharged from the practice so that we can provide care to other patients.

**Medical Records Fees**

Patients are entitled under federal law to have access to their protected health information and we follow all rules, guidelines, and exceptions to ensure compliance to patient rights. However, providers also have the right to compensation for records and our fees are reasonable cost-based fee for copies including the copying, supplies, labor, and postage of files, and or summaries.

We realize that temporary financial problems may affect timely payment of your account. If this should occur, please contact us for assistance in the management of your account. Our goal is to provide quality care and service. Please let us know immediately if you require any assistance or clarification from anyone with our business.

**Timeliness of Appointment**

We try to see everyone in a timely manner but if we are taking too long, please let our receptionist know so we can best serve your needs and reschedule you if necessary.

I have read understand the above financial policy. I agree to assign insurance benefits to ***Nihon Medical Clinic*** whenever applicable. I also agree, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collection if such action become necessary.

Signature of Insured or Authorized Reprehensive: _____

Date: _____