# Patient Registration

**Thomas Rohde, M.D. Kim Kish, N.P. Monica Duran, M.D.**

**PATIENT**

Full Legal Name ______________________________ Soc Sec #____________________

Street Address ______________________________ Birth date _____/_____/________

City ______________________ State __________________ ZIP __________________

Sex: ☐ Male ☐ Female Marital Status __________________

Referring Physician ______________________ Home Ph (_____) _______________

Work Ph (_____) _______________ Cell Ph (_____) ______________________

E-Mail ______________________________May we e-mail you at this address? ☐Yes☐No

Work Status: ☐Full-time ☐Part-time ☐Retired ☐Not Employed

Student Status: ☐Full-time ☐Part-time

Employer ________________________ **Is this a work injury? ☐Yes ☐No /Accident? ☐Yes ☐No**

Emergency Contact Name ____________________Emergency Contact Phone (_____) ____________

---

**PERSON RESPONSIBLE FOR PAYMENT** Please complete if **not** the same as the patient.

Full Legal Name ______________________________Relationship to Patient ____________________

Birth Date _____/_____/_____ Soc Sec # ________________________

Home Phone (_____) ___________ Work Ph (_____) ____________ Cell Ph (_____) _____________

Street Address ________________________________________________________________

City _________________________ State _________________ ZIP ___________________

E-Mail ____________________________________ May we e-mail you at this address? ☐Yes ☐No

---

**FIRST (PRIMARY) INSURANCE** Complete this section with insurance **card holder** data.

***No appointment will be scheduled without a front and back copy of your insurance card(s).***

Will you be self pay? ☐ Yes ☐ No *(Self pay patients are required to pay in full at time of service.)*

Name of Insurance Company ______________________________________________________

Card holder name **exactly** as shown on card ____________________________________________

Social Security #__________________ Birth Date _____/_____/_____ Sex: ☐ Male ☐ Female

**Member ID #** ____________________________ **Policy Group #**______________________________

**Remaining Deductible: $**______________________ **Co- Payment: $**_________________________

**SECOND (SECONDARY) INSURANCE** Complete this section with insurance **card holder** data.

Name of Insurance Company ______________________________________________________

Card holder name **exactly** as shown on card____________________________________________

Soc Sec # _______________ Birth date _____/_____/_______ Sex: ☐ Male ☐ Female

**Member ID #** ____________________________ **Policy Group #**______________________________

---

**HOW YOU LEARNED ABOUT US** What influenced your decision to come to our practice?

☐ Brochure / Flyer ☐ Billboard ☐ Employer ☐ Family / Friend ☐ Television ☐ Newspaper

---

**Signature Patient/Legal Guardian:**___________________________________ **Date:** ___________

# New Patient Health History

**Name**________________________________________ **Date of Birth**_________________

| Name of Medicine | Dose (ex: 500mg) | Frequency (ex: twice a day) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

| Allergies (please list what you are allergic to and the reaction) |
|---|
| |
| |
| |
| |
| |

| Surgeries (please list name of surgery and date) |
|---|
| |
| |
| |
| |

| Tobacco (please list type and amount on a daily basis) |
|---|
| |
| |

| Alcohol (please list type and amount on a daily basis) |
|---|
| |
| Any recreational drugs? |
| |

Please write in any concerns or additional information you feel is important to your care.

Social History

marital status (please circle) married, single, divorced, minor, partner

Any children?_______________________________________

Type of work:_______________________________________

Level of education (elementary, high school, associates, bachelor, additional)

____________________________________________________

| Family Medical History | diabetes | | high blood pressure | | heart attack | | cancer | | strokes | | depression | other |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| mother | | | | | | | | | | | | |
| father | | | | | | | | | | | | |
| siblings | | | | | | | | | | | | |
| mom's mother | | | | | | | | | | | | |
| mom's father | | | | | | | | | | | | |
| dad's mother | | | | | | | | | | | | |
| dad's father | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |

**Review of Systems: please check mark any of the following that are positive**

GENERAL:
- Fever ☐
- Chills ☐
- Sweats ☐
- Loss of appetite ☐
- Fatigue ☐
- Malaise ☐
- Weight loss ☐
- Headache ☐

EYES:
- Blurry ☐
- Double vision (Diplopia) ☐
- Irritation ☐
- Discharge ☐
- Vision loss ☐
- Eye pain ☐
- Photophobia ☐

EARS, NOSE, THROAT:
- Ear ache ☐
- Ear discharge ☐
- Tinnitus ☐
- Decreased hearing ☐
- Nasal congestion ☐
- Nose bleeds ☐
- Sore throats ☐
- Hoarseness ☐
- trouble swallowing ☐

HEART:
- Chest pains ☐
- Palpitations ☐
- passing out -Syncope ☐
- shortness of breath: ☐
- on exertion ☐
- lying down-Orthopnea ☐
- at nighttime-PND ☐
- swelling in ankles ☐

RESPIRATORY:
- Cough ☐
- Dyspnea ☐
- Excessive sputum ☐
- coughing blood-Hemoptysis ☐
- Wheezing ☐

DIGESTIVE:
- Nausea ☐
- Vomiting ☐
- Diarrhea ☐
- Constipation ☐
- Change in bowel habits ☐
- Abdominal pains ☐
- black stools-Melena ☐
- blood in stools-Hematochezia ☐
- Jaundice ☐
- Heartburn ☐

URINARY:
- Incontinence ☐
- Dysuria ☐
- blood in urine-Hematuria ☐
- Urinary frequency ☐
- Amenorrhea ☐
- bleeding during ☐
- month-Menorrhea ☐
- Abnormal vaginal bleeding ☐
- Vaginal discharge ☐
- Pelvic pain ☐
- urination at night-Nocturia ☐

MUSCLES/JOINTS:
- Back pain ☐
- Joint pain ☐
- Joint swelling ☐
- Muscle cramps ☐
- Muscle weakness ☐
- Stiffness ☐
- Arthritis ☐

SKIN:
- Rash ☐
- Itching ☐
- Dryness ☐
- Suspicious lesions ☐

NEURO:
- Memory loss ☐
- Transient paralysis ☐
- Weakness ☐
- Paresthesias ☐
- Seizures ☐
- passing out-Syncope ☐
- Tremors ☐
- Vertigo ☐
- Headache ☐

PSYCHOLOGY:
- Depression ☐
- Anxiety ☐
- Mental disturbance ☐
- Suicidal ideation ☐
- Homicidial ideation ☐
- Hallucination ☐
- Paranoia ☐

ENDOCRINE:
- Cold intolerance ☐
- Heat intolerance ☐
- Hair loss ☐
- frequent drinkingPolydipsia ☐
- eating too much-Polyphagia ☐
- frequent urine-Polyuria ☐
- Weight change ☐

BLOOD:
- Abnormal bruising ☐
- Bleeding ☐
- Enlarged lymph nodes ☐

ALLERGIC:
- skin rash-Urtecaria ☐
- Post nasal drainage ☐
- Nasal congestion ☐
- Itchy eyes ☐
- Hay fever ☐
- Frog/lump sensation ☐
- Persistent infections ☐
- HIV exposure ☐

**Thomas Rohde, M.D., LTD**
**3798 E. Fulton Avenue**
**Decatur, IL 62521**

# Financial Policy

1. **We provide services to YOU, not your insurance company**. YOU are therefore financially responsible for your bill. This includes co-payments, deductibles, co-insurance, and any patient due balance.
2. **All office visits are to be paid on the day of service** by cash, check, or credit card unless you have made other arrangements with the office staff prior to the day that you are seen for your appointment. Checks returned for non-sufficient funds will incur a $25.00 service fee.
3. Your insurance contract requires us to collect your co-payment at the time of your visit. If you ask us to bill you for your co-payments **we will add a $20 convenience fee** for this delayed payment service.
4. I will call my insurance to ensure that Dr. Rohde, Dr. Duran, and Kim Kish, N.P. are in- network. If they are not, I understand that I am responsible to pay for my visit at the time of service and that I will need to file with my insurance for reimbursement at out of network rates.
5. If you have insurance and we are in network with your carrier we will be happy to assist you in processing the claim for services rendered for up to **two** insurance carriers when the appropriate information is provided to our office. **It is YOUR responsibility to provide us with current insurance information and to understand your insurance co-payment.** Remember that insurance plans vary greatly in amounts that they will pay -- from nothing to 100% of the bill. Sixty (60) days after this office files a claim on your behalf any outstanding amount is due in full. **Any outstanding balance will need to be paid, or a monthly payment plan must be established that is acceptable to the office, before you are seen for an appointment.** It is your responsibility to call your insurance company if the deadline for payment is approaching. Once you receive a billing statement from us payment of any balance is due in full in 15 days. If you pay and later the insurance also reimburses us, a check from us will be written to you in the amount of your overpayment.
6. Not all insurance plans cover all services. It is YOUR responsibility to determine if a specific service, test, or procedure is covered by your insurance plan. We will ask you to sign an Advanced Beneficiary Notification (ABN) form for services, tests, and procedures that are often considered to be “not covered”, "investigational", or cosmetic in nature. In the event your insurance plan determines a service to be “not covered” you agree that by giving consent to the service, test, or procedure, you are responsible for the entire charge. Payment is due upon receipt of a statement from our office
7. **Collection Fees**: In the event that any unpaid balance, No-show/late fees, NSF fees, etc. are referred to a collection agency, attorney, or any other service for collection, **a collection fee of 43% of the unpaid balance will be added to the unpaid balance due**. I agree that I or the responsible party agree to pay any costs incident to collection incurred directly or indirectly by the creditor, collection agency, attorney or other service. These costs may include but are not limited to court costs, attorney’s fees, sheriff’s fees, interest, and late fees. I agree that the authorized collection fee (43% of the unpaid balance) and any additional incidental costs incurred to collect the outstanding amounts constitutes the actual total costs incurred to collect any amounts due from me or my responsible party under this agreement in the event of placement or referral for collection.
8. **We have a “No Show” policy.** We cannot provide the quality care you deserve if you miss a scheduled appointment. This is also a time slot that could have been extended to another patient. **We charge $50.00 for missing a routine appointment** or for not cancelling an appointment 24 hours prior to the appointment. **We charge $100.00 if you miss or fail to cancel a lengthy consultation or procedure appointment**. Insurance will NOT cover these fees and you will be personally responsible for them.
9. We understand that work and liability accidents happen, however we do not file to workman’s compensation or to other liability insurance companies such as auto insurance. Litigation is often lengthy and payment is not received in a timely manner. We will ask you to pay for your visit at the time you are seen and provide you with a receipt to file with your carrier for your settlement.

10. There are various fees for the completion of: disability forms, FMLA paperwork, auto insurance forms, and bank forms of all types. Similarly, a fee will be assessed for the provision of medical records copies in certain circumstances. This fee must be paid before any paperwork will be completed. We regret these additional charges but the number of forms completed has become overwhelming and requires considerable staff and physician time. If you wish your insurance to cover the cost for completion of forms you may schedule an appointment and the doctor will complete the forms together with you. You WILL be responsible for any co-payment and charges for that visit.
11. Parents: 1) By law, the legal guardian must authorize treatment of minor children for whom they have custody. If the parent cannot accompany the child to their appointment for whatever reason, the parent must contact the nurse prior to the visit so that we may discuss treatment, and you can grant permission for treatment. 2) The parent with legal custody of the child is responsible for the bill, regardless of whose insurance policy the child is covered under. In the case of joint custody, the parent who brings the child in for care is responsible for the bill.
12. Please feel free to discuss any questions you have with our business office staff.

I have read this form and understand it. My questions have been answered to my satisfaction:

_________________________________ ____/____/______ _______________________

Name Birth date Social Security Number

____________________________________________ ____________________________

Patient Signature Date

____________________________________________ ____________________________

Responsible Party Signature Date

| | **RENEW TOTAL BODY WELLNESS CENTER**<br>**Thomas Rohde, M.D., FAAFP**<br>**3798 E. Fulton Avenue**<br>**Decatur, IL 62521**<br>**217-864-2700**<br>**www.DrRohde.com / www.RenewMyImage.com** |
|---|---|

# Consent For Treatment

Patient's Full Legal Name_____________________________________________

Birthdate (mo/day/year) ____/___/______ Social Security #________________

**Consent for Treatment**

I am asking for, and consent to receive, care from Thomas Rohde, M.D. and other health care providers at the Renew Total Body Wellness Center. I understand this care may include 1) tests and procedures (which may include laboratory tests and X-ray examinations) and 2) medical and surgical treatment. I permit the health care providers, their associates and assistants, and their employees to provide me with services that are considered necessary or advisable.

No guarantees have been made to me about the outcome of this care. I may choose not to have recommended tests, procedures, and healthcare performed. In the event I decide to refuse the recommended treatment, considered necessary or advisable, by the health care providers I relieve Thomas Rohde, M.D. and its health care providers of all responsibility for any ill effects which might result from my action.

I acknowledge that I have read the consent for treatment and conditions listed above and further acknowledge that I am the patient or that I am duly authorized by the patient as a legal representative to execute and accept the terms as set forth herein.

**2. Other**

I permit a copy of this consent to be used in place of the original. This consent shall remain in effect until rescinded in writing. I understand that I may revoke this consent at any time by giving written notice of my desire to do so to Thomas Rohde, M.D. or any of its health care providers.

If you are not the patient, please specify your relationship to the patient: _____________________

_____________________________________________________ ___________________

Signature of Patient (or Legal Guardian if Patient is a Minor) Date

_____________________________________________________ ___________________

Signature of Guarantor (Person Responsible for Payment) Date

**Consent for Release and Use of Confidential Information and Receipt of Notice of Privacy Practices Letter**

**Thomas Rohde, M.D., LTD**
**3798 E. Fulton Avenue**
**Decatur, IL 62521**

I, _______________________________________________, hereby give my
*(Name of Patient or Authorized Agent)*

consent to Thomas Rohde, M.D. to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record of ________________________________________.

I acknowledge receipt of the physician's Notice of Privacy Practices. The notice of privacy practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that Dr. Rohde has reserved a right to change his privacy practices that are described in the notice. I also understand that a copy of any revised notice will be provided to me or made available.

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 Dr. Rohde or his staff. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be mailed to Dr. Rohde's office.

You have my permission to release medical/financial information to:

| Name | Relationship |
|---|---|
| | |
| | |
| | |

Signed: ________________________________________ Date: ________________

If you are not the patient, please specify your relationship to the patient:

________________________.

# RENEW TOTAL BODY WELLNESS CENTER

## THOMAS W. ROHDE, M.D., FAAFP

**www.DrRohde.com**

**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

**I,** ______________________________ **Phone**: ____________________ **DOB**:__________
**Patient Name**

**Authorize:** ______________________________ ______________________________
**(Name of Institution/Healthcare Provider)** **Street Address**

______________________________________________________________
**City, State, Zip Code**

**to disclose to:** **Thomas W. Rohde, M.D., FAAFP**
**3798 E. Fulton Avenue**
**Decatur, IL 62521**

**information from my health record. I understand that the specific type of information to be disclosed includes: (please strike any non-desired disclosures) medical records, including alcohol abuse, drug abuse, mental illness, HIV/AIDS testing or other sensitive information and patient's record cards, x-rays, x-ray readings and reports, laboratory records and reports, all tests of any type and character and reports thereof, hospital records, reports, discharge summaries, correspondence, and any and all records pertaining to medical care, history, condition, treatment, diagnosis, prognosis or etiology:**

______________________________________________________________

______________________________________________________________

**and that this disclosure is made for the following purpose(s):**

______________________________________________________________

______________________________________________________________

______________________ ______________________________________________
Date of Signature Signature of Patient or Person Authorized to Sign on Behalf of patient*

______________________________________________
Relationship to Patient (if Applicable)

______________________ ______________________________________________
Date of Signature Witness

NOTE TO RECIPIENT OF INFORMATION: This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosure of this information without the specific written consent of the patient or legal representative involved.

*Person authorized by the patient means the parent, guardian, or legal custodian of a minor patient or a patient adjudged incompetent; the spouse or personal representative of a deceased patient; or any person authorized in writing by the patient, which is witnessed and dated.