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. / MONICA DURAN, M.D. / KIMBERLY KISH, APN/CNP
3798 E. FULTON AVENUE…..DECATUR, IL 62521
PHONE: (217) 864-2700…..FAX: (217) 422-3930
E-MAIL: healinghappenshere3798@gmail.com

PAYMENT/FINANCIAL POLICY

1. **Insurance**. We participate in some insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. If you have insurance and we are in network, we will assist in processing the claims for services rendered for up to two insurance carriers. It is your responsibility to provide us with current insurance information and to understand your insurance benefits. Sixty days after this office has filed a claim on your behalf, any outstanding balance is due in full. It is your responsibility to call your insurance company if the deadline for payment is approaching. If you pay and later the insurance reimburses us, you will receive a refund from us. Once you receive a statement from our office, you have fifteen (15) days to pay in full.

2. **Co-payments and deductibles**. All co-payments and deductibles 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 payments from patients can be considered fraud. Please help us in upholding the law by paying at each visit.

3. **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 services. These costs may include but are not limited to court costs, attorney fees, sheriff 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.

4. **Non-covered services**. Not all insurance plans cover all services. It is your responsibility to determine if a specific service, test, or procedure is covered. You will be expected to sign an Advanced Beneficiary Notice (ABN) for services, tests, and procedures that may be considered "non-covered", "investigational" or cosmetic in nature. By signing the ABN, you agree that by giving your consent to the service, test, or procedure, you are totally responsible for the entire charge listed on the ABN. Depending on the circumstances, you must pay for these services in full at the time of visit or payment is due within fifteen (15) days upon receipt of a statement from our office.

5. **Proof of insurance**. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of both your driver's license to be able to positively verify your identity and your current valid insurance card(s) to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for the balance of a claim.

6. **Claims submission**. Providing we are in network with your insurance carrier, we will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

7. **Coverage changes**. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

8. **Nonpayment**. If your account is over 60 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis. After that 30-day period, no refills will be given.

9. **Missed appointments**. **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.

10. **Third Party Insurance.** We understand that work and liability accidents happen, however we do not file to Workman' Compensation or to other liability insurance companies such as auto insurance. We will ask you to pay for your visit at the time of service and provide you with a receipt to file with your carrier for your settlement.

11. **Forms.** At times, you may need our help in filling out various forms such as FMLA, disability, auto insurance, and bank forms of all types. There is a $25 fee payable by you prior to filling these forms out unless you are seen by a provider. You will be responsible for any copay and charges for that visit.

12. **Parents.** 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 to discuss treatment and grant permission for treatment. 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.

Thank you for choosing us as your primary care provider. Our practice is committed to providing the best treatment to our patients and affordable health care. Our prices are representative of the usual and customary charges for our area.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party Date

RENEW TOTAL BODY WELLNESS CENTER
THOMAS W. ROHDE, M.D. LTD.
3798 E FULTON DRIVE
DECATUR, IL 62521
PHONE: (217) 864-2700
FAX: (217) 422-3930
www.drrohde.com

Credit Card Payment Authorization Form

Sign and complete this form to authorize Renew Total Body Wellness Center to make a debit of One Hundred Dollars ($100.00) to your credit card listed below. This information is necessary to secure an appointment. In the event that you are a "No Show" or do not give us a 24-hr cancellation notice for your appointment this Reservation Fee will not be refunded.

Please complete the information below:

I, _____, authorize Renew Total Body Wellness Center to charge my credit card account indicated below for One Hundred Dollars ($100.00). I understand no appointment will be scheduled without this Reservation Fee.

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

Account Type: ☐ Visa ☐ MasterCard ☐ Discover

Cardholder Name _____

Account Number _____

Expiration Date _____

CVV: _____

SIGNATURE _____ DATE _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for the amount indicated above only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

RENEW TOTAL BODY WELLNESS CENTER
Thomas Rohde, M.D., FAAFP
3798 E. Fulton Avenue
Decatur, IL 62521
217-864-2700
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.