Notice of Privacy Practice Acknowledgement

Dr. Mayra A. Arzon
1 Memorial Drive
Suite 101
Decatur, Il 62526

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also under you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

I attempted to obtain the patient's signature in acknowledgement on this *Notice of Privacy Practices Acknowledgement*, but was unable to do so as documented below.

Reason: _____

Date: _____

Initials: _____

Dr. Mayra A. Arzon
1 Memorial Drive
Suite 101
Decatur, Il 62526

Date: _____

Patient Name: _____

No Show: There will be a $50.00 charge to the account for any appointment that is missed without calling and cancelling. Our policy is to give a 24-hour notice to cancel an appointment.

Insurance Card: Needs to be presented at the first initial visit and then only presented when insurance information has changed. This is to be sure that the correct insurance is being billed for each visit.

Co-Pays: Co-Pays are due at the BEGINNING of every appointment. If you are sending your child to their appointment alone or with someone else, please be sure to send the co-pay in with them or call and pay it over the phone ahead of time.

Records: If you choose to leave the practice and request records to be sent to another office there is a fee of $41.00 per each patient chart that needs to be transferred. The fee for the chart must be paid before our office will release any records to a new doctor.

Parent/Legal Guardian Signature: _____

Mayra A. Arzon M.D.
One Memorial Drive
Suite #101
Decatur, IL 62526

Date:

Pt Name:_____

Medicaid will **NOT** pay more than one provider on the same date of service for any type of visit.

Under this policy, any Medicaid patient will agree to not see any other provider on the same date of service as seen by Dr. Arzon. Doing so will hold the patient responsible for the cost of the visit with Dr. Arzon.

By signing this document I agree to the above terms & conditions.

Parent Signature_____

New patient intake form

Patient Name:	Patient Address: Street City State Zip code
Date of birth or due date:	Male or Female

Mother's Information : Name:		Date of Birth
Address if different from above:		Phone#
Previous address if applicable :		Alternate Phone #
Employer:	Occupation:	E-mail

Father's Information : Name:		Date of Birth
Address if different from above:		Phone#
Previous address if applicable:		Alternate Phone #
Employer:	Occupation:	E-mail

Primary Insurance Co name:	Policy holder's name:	
Insurance remittance address	Subscriber #	Group #
Secondary Insurance Co name:	Policy holder's name:	
Insurance remittance address	Subscriber #	Group #

Previous Physician Name :	Name of practice/Place:
Reason for change?	City&State:

Do you vaccinate and will you vaccinate your child/children for all routine immunizations? _____
Do you plan to vaccine for coronavirus? _____
Does your child/Children have any medical issues? _____ * if yes please list any diagnoses or issues _____

I have read and filled in the above questions to the best of my knowledge. I authorize the physician to release and information required in the course of exam and treatment and permit payment directly to the doctor by my insurance company for any services rendered. I recognize and accept full responsibility for any remaining balance after payment of such benefits.

- Note Medicaid will not be accepted as secondary insurance!!!

Signature: _____ Date: _____

Emergency Contact Info:
Name:
Phone #
Relation:

Patient Registration
Dr. Mayra Arzon
1 Memorial Dr. Suite 101 Decatur Il. 62526
217-875-0690

Patient
Full Legal Name_____

Nickname_____

Soc Sec #_____ D.O. B._____ Sex___ Race_____ Ethnicity_____

Preferred Language_____

Guarantor's Name_____

Address_____ City_____ State___

Zip_____

Home Ph(____)_____ Cel Ph (_____)_____ Work Ph (_____)_____

Other Ph (_____)_____ E-Mail_____

Preferred Method of Contact: Home Work Cell Email

Mother's Name _____ D.O.B._____ Employer_____

Mother's Soc Sec #_____

Father's Name_____ D.O.B._____ Employer_____

Father's Soc Sec#_____

Step Mother's Name_____ D.O.B._____

Step Father's Name _____ D.O.B._____

Sibling's Name's and D.O.B._____,_____

_____,_____,_____

_____,_____

Who Lives in the house with patient: _____

Who Has permission to bring the child to appt. in place of parent _____

_____

Emergency Contact Name_____ Phone #_____

Primary Insurance Co. Name_____

Card holders name exactly as shown on card

_____

Secondary Insurance Co. Name_____

Card holders name exactly as shown on card _____

Previous Physician?_____

Reason for change?_____

I have read and filled in the above questions to the best of my knowledge. I authorize the physician to release any information required in the course of exam and treatment and permit payment directly to the doctor by my insurance company for any services rendered. I recognize and accept full responsibility for any remaining balance after payment of such benefits.

*******NOTE- Medicaid (IDPA, Health Alliance Connect, Molina) will NOT be accepted as Secondary Insurance

.

Signature_____ Date_____