The Center for Weight Loss and Internal Medicine / Gurnee Weight Loss Center
501 North Riverside Drive, Suite 216 • Gurnee, Illinois 60031
Phone: 847.625.8300 • Fax: 847.625.8862 • Email: info@gurneeweightloss.com

CONDITIONS AND CONSENT TO TREATMENT AND HEALTH INFORMATION PRIVACY PRACTICES

Patient Name:_____ **Date of Birth:**_____

CONSENT FOR TREATMENT:
I authorize the physicians, employees, agents and independent contractors of The Center for Weight Loss and Internal Medicine / Gurnee Weight Loss Center, to render or refer Medical, Surgical, Audiology, Weight Loss or other health related care, evaluation and treatment for me. I understand that the physicians, employees, agents and independent contractors of The Center for Weight Loss and Internal Medicine / Gurnee Weight Loss Center, have the right to refuse to render or refer care for me at their professional discretion.

DISCLOSURE OF HEALTH INFORMATION:
I authorize the physicians, employees, agents and independent contractors of the Center for Internal Medicine and Preventive Care to use or disclose my protected health information for the purpose of diagnosing, rendering or referring for treatment, obtaining payment for services provided and as necessary for conducting the operations of The Center for Weight Loss and Internal Medicine / Gurnee Weight Loss Center. Further, I authorize the staff of The Center for Weight Loss and Internal Medicine / Gurnee Weight Loss Center to leave voicemail messages on the telephone numbers I provide regarding appointments, testing, test results and medical treatment.

NOTICE OF PRIVACY PRACTICES:
The Center for Weight Loss and Internal Medicine / Gurnee Weight Loss Center protects patient health information in compliance with Federal law. I acknowledge that I have received a copy of the Notice of Privacy maintained by The Center for Weight Loss and Internal Medicine / Gurnee Weight Loss Center.

INSURANCE COVERAGE/NOTICE OF BENEFICIARY/ASSIGNMENT OF BENEFITS:
I authorize any and all third-parties responsible for payment of charges for healthcare services rendered to me, including but not limited to; insurance companies, government entities, Medicare and Medicaid (IDPA), to pay benefits directly to The Center for Weight Loss and Internal Medicine / Gurnee Weight Loss Center, or its agent.

FINANCIAL RESPONSIBILITY:
I understand that I am financially responsible for all charges for services rendered by The Center for Weight Loss and Internal Medicine / Gurnee Weight Loss Center. I understand that all co-payments, deductibles and co-insurance are due at the time of service unless prohibited by contract or other arrangements are made with the office of The Center for Weight Loss and Internal Medicine / Gurnee Weight Loss Center. I further understand that if the third-party responsible for payment of charges for healthcare services rendered to me does not pay, I may be responsible for the full amount due to The Center for Weight Loss and Internal Medicine / Gurnee Weight Loss Center. In the event that my account is referred for collection, I agree to pay all costs of collection. I also understand that I may be responsible for: a charge of $50 for each incident of a refused credit card charge, an appointment not cancelled 24 hours prior to scheduled visit, or a returned check, and a charge of $40 if I cancel a group session or fail to obtain ordered tests in a timely manner requiring cancellation of my appointment.

NOTICE TO PARENTS OR GUARDIANS:
The individual signing this document for a patient under the age of 18 certifies that they have the legal authority to consent and agree to terms and conditions described herein on behalf of patient. Patients under the age of 18 must be accompanied by a parent or guardian to every appointment.

I Certify:
1. That I have read or have had this document read to me;
2. That I was given an opportunity to ask questions & that all questions were answered to my satisfaction, and;
3. That I understand all the terms & conditions described in this document & accept these terms & conditions.

Patient/Parent/Guardian Signature:_____

Witness signature:_____ **Date:**_____

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PATIENT INFORMATION

Patient Name:

_____

Date of Birth:_____ Age:_____

Social Security Number:_____

Gender: M F Martial Status: M S D W

Home Address:

Street:_____

City:_____

State:_____ Zip Code:_____

Contact Information:

Home:_____

Cell:_____

Work:_____

Fax:_____

Email:_____

Emergency Contact:

Name:_____

Relationship:_____

Phone:_____

If Patient is a Minor:

Mother:_____

Phone:_____

Father:_____

Phone:_____

PHYSICIANS

Primary Care Physician:

Name:_____

Phone:_____

Referring Physician

Name:_____

Phone:_____

PHARMACY

Name:_____

Street:_____

City:_____

Party Responsible for Payment:

Relationship (please circle):

Self Spouse Mother Father Other

Name:_____

Social Security Number:_____

DOB:_____

Street:_____

City:_____

State:_____ Zip:_____

Phone:_____

Occupation:_____

Employer:_____

Workers Compensation: Y N N/A

Date of Injury:_____

Auto Accident: Y N N/A

Date of Injury:_____

Referral Source:

_____

_____

SIGNATURES

Patient/Guardian:

_____

Referring Physician

Relationship:_____

Date:_____

Practice Employee:_____

Date:_____