Advanced Psychiatry of Elgin
Child, Adolescent and Adult Psychiatry
2130 Point Boulevard, Suite 200
Elgin, IL 60123
Telephone: 847.783.0307 Fax: 847.783.0730

PRACTICE & PRIVACY POLICIES ACKNOWLEDGEMENT

_____ _____

Patient's Name **Patient's Date of Birth**

I have the authority to act on behalf of "myself" or "patient" and to make medical decisions and enter into the obligations described below:

I hereby acknowledge that I have received a copy of the NOTICE OF PRIVACY PRACTICES describing the rights of a Patient and all Advanced Psychiatry of Elgin's provider's obligations regarding the use and disclosure of health information.

I request Advanced Psychiatry of Elgin to submit all medical charges to insurance companies, governmental agencies or their intermediaries, third party payers, and other entities, providing benefits to the patient. I authorize payment of medical benefits to Advanced Psychiatry of Elgin. I understand that Advanced Psychiatry of Elgin is billing these entities as a courtesy to me and that it is my responsibility to notify Advanced Psychiatry of Elgin of all information needed to bill on my behalf.

I understand that my Private Healthcare Information can be viewed and collaborated upon by Providers within Advanced Psychiatry of Elgin.

This office has a "zero tolerance" policy for any patient that presents to their appointment under the influence of alcohol or any other illicit drug. This office reserves the right to question a patient if it feels a patient is under the influence. If a patient does present to an appointment at this office under the influence, the appointment will be cancelled and the patient will be terminated as a patient at Advanced Psychiatry of Elgin.

MISSED APPOINTMENTS:
There will be a charge of $100.00 for missed appointments unless Advanced Psychiatry of Elgin receives a 24-hour notice in advance of cancellation.

I understand that I am always responsible for the balance on my account. If my insurance company, their intermediaries, or third party payers do not respond or pay my bill within a timely manner, I understand that I will be billed for charges and payment is due immediately. I will contact Advanced Psychiatry of Elgin office and coordinate a payment plan if I am unable to pay the balance due in full.

I understand that if my bill is paid in full, any additional funds received may be applied to other bills for Advanced Psychiatry of Elgin that are owed by me and the balance after the account is paid in full will be refunded to me.

In the event this account is assigned to a collection agency, I agree to pay all costs of collection, including court costs and reasonable attorney fees. I also understand that the patient will not be allowed to return to Advanced Psychiatry of Elgin until the charges at the collection agency have been paid in full.

_____ _____

Patient/Parent/Guardian Signature Today's date

May we leave messages on your answering machine or voicemail?_____

Phone number where we can leave messages:_____

Signature_____

Advanced Psychiatry of Elgin
Child, Adolescent and Adult Psychiatry
2130 Point Boulevard, Suite 200
Elgin, IL 60123
Telephone: 847.783.0307 Fax: 847.783.0730

Other persons or family members authorized to receive my medical information from this office:

_____	_____
Name	Relationship
_____	_____
Name	Relationship