Grand Rapids Thoracic Surgery, PLLC

NAME_____DATE OF BIRTH:_____

SEX: Male or Female (select) SOCIAL SECURITY NUMBER:_____

Contact Information:

MOBILE PHONE:_____ HOME PHONE:_____

WORK PHONE:_____EMAIL:_____

PREFERRED METHOD OF COMMUNICATION: (SELECT)
Mobile - Home Phone - Work Phone - Email

ADDRESS:_____

Payment Information:

INSURANCE: _____ID#_____

Effective Date:_____Group#_____

Guarantor:

PATIENT RELATIONSHIP TO GUARANTOR: SELF or _____ SEX: MALE OR FEMALE

GUARANTOR NAME_____DATE OF BIRTH_____ PHONE #:_____

ADDRESS:_____

Demographics

ETHNICITY_____PREFERRED LANGUAGE_____

RACE: (Select)

American Indian or Alaska Native
Asian
Black or African American
Native Hawaiian or Other Pacific
White
Patient declined to specify

Care Team:

Primary Care Physician:_____Phone:_____

Referring Physician:_____Phone:_____

PharmacyName:_____Phone:_____

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Next of kin/Emergency Contact:

NEXT OF KIN NAME:_____RELATION TO PATIENT_____

PHONE:_____ ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

PERSONAL HEALTH HISTORY

MAIN REASON FOR VISIT OR MAJOR EVENTS: (Please describe)

_____

_____

ONGOING MEDICAL PROBLEMS and /or PREVIOUS SURGERIES w/ DATES:
(Please describe)

_____

_____

ALLERGIES: (Please list)

_____

ARE YOU ALLERGIC TO LATEX? YES OR NO
ARE YOU ALLERGIC TO PENICILLIN? YES OR NO

CURRENT MEDICATIONS (INCLUDING OVER THE COUNTER AND VITAMINS): (Please list)

_____

_____

FAMILY HEALTH HISTORY: (Please list)

_____

_____

PERSONAL HEALTH HISTORY (con't)

ACTIVITY:
DO YOU EXCERSISE REGULARLY? YES OR NO
IF SO, WHAT IS YOUR ROUTINE?_____

SOCIAL HISTORY

CIGARETTE SMOKING: (PLEASE CIRCLE)

Never smoked

Former smoker WHEN DID YOU QUIT?_____
HOW MANY YEARS DID YOU SMOKE?_____

Current smoker HOW MANY PACKS PERDAY?_____
HOW MANY YEARS?_____

ALCOHOL USE: (PLEASE CIRCLE)

None
Less than 1 drink per day
1-2 drinks per day
3 or more drinks per day

TO THE BEST OF MY KNOWLEDGE THE ABOVE INFORMATION IS TRUE AND CORRECT. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM MY DOCTOR IF ANYTHING CHANGES ABOVE.

PATIENT:_____DATE:_____

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Financial Policy

In order to better serve your needs and clarify any questions you may have regarding your insurance, we have adopted the following financial policy:

1. We must have a copy of your insurance card at the time of service. If you have multiple insurances, please present all cards.
2. If Dr. Willekes participates with your insurance carrier, meaning he is "in-network," we will submit claims for his professional services directly to your insurance carrier for payment as an in-network provider. You will be responsible for any and all applicable co-payments, co-insurance and deductibles at the time of service.
3. If Dr. Willekes does not participate with your insurance, meaning he is "out-of -network," for your convenience, we may submit claims for his professional services directly to your insurance as an out-of-network provider.
4. Financial responsibility lies with you and your insurance company. It is your responsibility to ensure your insurance pays accordingly. In the event your insurance company denies payment for any services rendered, you will be responsible for payment. We will be available to assist in any way possible with your insurance concerns and problems.
5. Because Dr. Willekes is sensitive to the financial concerns of his patients, payment plans are available upon request.
6. Dr. Willekes allows sufficient opportunity for patients to submit payment. If payment is not made within 30 days of request, your account may be turned over to a collection agency.
7. *In the event your insurance carrier forwards any payment for reimbursement of out-of-network benefits directly to you, you agree to endorse such payment to Dr. Willekes and remit payment directly to Dr. Willekes via certified mail, return receipt or will personally deliver the check to Dr. Willekes' office within five days of receipt.

I have carefully read this financial policy and understand that I agree to be responsible for my medical expenses; therefore I authorize my insurance company to pay directly to Dr. Willekes and/ or provide any information concerning payment of my bill. I agree to the financial policy above and I accept responsibility for any balances not covered by my insurance company.

Patient Signature: _____
Printed Name: _____
Date: _____
Witness: _____
Printed Name: _____
Date: _____

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PRIVACY NOTICE AKNOWLEDGEMENT

I acknowledge receipt of the "notice of privacy". My signature only acknowledges my receipt of the Notice of Privacy.

Name of Patient:_____

Signature of Patient:_____

Date:_____

Signature of Patient representative:_____

Relationship to patient:_____

If unable to obtain patient's signature, please state reason and sign:

_____

_____I give permission to the office of Dr. Willekes to leave detailed messages such as: nature of call, test results, testing or surgery information; on my home, cell and or/ confidential work voicemail.

_____I give permission to the office of Dr. Willekes to leave general messages such as: callers name, appointment reminder and request for a call back ; on my home, cell and or/ confidential work voicemail.

I give permission to the office of Dr. Willekes to speak to the following if you are unable to speak to our office directly. (We will **ONLY** speak to the person (s) listed below.)

1._____Relationship to Patient:_____

2._____Relationship to Patient:_____