CHRISTIE CLINIC
Medicine for Your Life

Patient Information

Date and Time of Appt._____
Dr._____
History#_____
Primary Care Provider_____
Financial Class_____

1. Patient Information

Name (Last First Middle) | Maiden/Other | Marital Status (Circle One) S D M W

Social Security # | Date of Birth | Phone # | Sex

Address | Apt # | City | State/Zip Code

Employer | Occupation | Business Phone | Length of Employment

Are you a student? (Please circle one)
No Yes ☐ full time ☐ part time

Spouse's Name | Employer | Business Phone

Nearest Relative not residing with you | Address | Home Phone | Relationship

Person to Notify in case of emergency | Address | Home Phone | Relationship

Business Phone

2. Responsible Party (If the patient is under 18 years of age or if someone other than the patient is responsible for the bill.)

Name | Address | City | State/Zip Code

Home Phone | Business Phone | Occupation | Employer | Relationship to Patient

3. Medical Insurance Information

Primary Insurance Company Name | **Group #** | **Member ID #** | **Effective Date** | **Carrier #**

Address | Telephone #

Policyholder (name, relationship to patient) | S.S. # | Employer | Birthdate

Secondary Insurance Company Name | **Group #** | **Member ID #** | **Effective Date** | **Carrier #**

Address | Telephone #

Policyholder (name, relationship to patient) | S.S. # | Employer | Birthdate

Medicare # | **Part B Effective Date** | **Still Employed** ☐ **Yes** ☐ **No** | **Spouse Employed** ☐ **Yes** ☐ **No**

Authorization to File/Release Information: I hereby authorize Christie Clinic, P.C. to release any medical information to my insurance company or third party payers or its agents for completion of insurance claims and determination of benefits.
Medicare Patient's Signature: I authorize any holder of medical or other information about me to release to the Social Security Administration and/or the Medicare Program or its intermediaries or carriers or to the Professional Standards Review Organization.
Assignment of Benefits: I assign payment directly to Christie Clinic, P.C. for all medical and/or surgical services provided to me by Christie Clinic, P.C. A copy of this authorization and assignment is to be considered valid as an original.

I certify that the above information is true and correct.

Signature of Patient or Legal Guardian _____ Date _____

Employee Name _____

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Your Statement of Account
Services not covered by insurance due to annual deductible, co-payment, co-insurance, non-covered services, usual and customary or termination of benefits are the responsibility of the patient.

Your monthly Statement of Account will reflect the patient responsibility portion of the charges assessed to your account during the prior billing cycle. Payment is due on those monthly charges within 30 days from the "Statement Date." The "Statement Date" appears near the top right-hand corner of your Statement of Account. The bottom center portion of your Statement of Account shows your aging balances from prior Statements of Account.

There will be imposed a FINANCE CHARGE on any balance of a Statement of Account remaining unpaid for 90 days or more. This is figured by taking the balance you owe on your last Statement of Account and subtracting any unpaid FINANCE CHARGE, and any payments and credits received within the first 27 days of the present billing cycle. Any portion of that balance remaining which is still 90 days past due will be subject to a FINANCE CHARGE. Payments received by us within 90 days of when you were first billed for services will have been credited to your account and a FINANCE CHARGE will not accrue on those amounts so paid.

The FINANCE CHARGE on balances over 90 days past due is calculated at a periodic rate of 1 1/2 % per month (which is at an ANNUAL PERCENTAGE RATE OF 18%) or a flat rate of $.50 per month, whichever is greater.

Your Billing Rights
If you think your bill is wrong, or if you need more information about a transaction on your bill, write to us at the following address:

Christie Clinic, P.C.
Customer Service Department
101 W. University Avenue
Champaign, IL 61820

Write to us as soon as possible. We must hear from you no later than 60 days after we sent you the first Statement of Account on which the error or problem appeared. You can telephone us, but doing so will not preserve your rights.

In your letter, give us the following information:

- Your name and account number
- Dollar amount of the suspected error
- Describe the error and explain, if you can, why you believe there is an error. If you need more information, describe the item you are not sure about.

Your Rights and Our Responsibilities After We Receive Your Written Notice
We must acknowledge your letter within 30 days, unless we have corrected the error by then. Within 90 days, we must either correct the error or explain why we believe the Statement of Account was correct.

After we receive your letter, we cannot try to collect any amount you question, or report you as delinquent. We can continue to bill you for the amount you question, including FINANCE CHARGE. You do not have to pay the parts of your Statement of Account that are in question.

If we find that we made a mistake on your Statement of Account, you will not have to pay FINANCE CHARGES RELATED TO ANY QUESTIONED AMOUNT. If we didn't make a mistake, you may have to pay FINANCE CHARGES, and you will have to make up missed payments on the questioned amount. In either case, we will send you a statement of the amount you owe and the date that it is due.

If you fail to pay the amount that we think you owe, we may report you as delinquent. However, if our explanation does not satisfy you and you write to us within 10 days, telling us that you still refuse to pay, we must tell anyone we report you to that you have a question on your bill. We must also tell you the name of anyone we reported you to. We must tell anyone we report you to that the matter has been settled between us when it is resolved.

It is the responsibility of the patient to confirm benefits with their insurance carrier prior to receiving healthcare services and not the responsibility of Christie Clinic.

I understand that Christie Clinic, P.C. does not accept responsibility for collection of my insurance benefits or negotiate the settlement of a disputed claim. I am responsible for payment of all clinic charges regardless of anticipated insurance coverage. Christie Clinic, P.C. does not accept "Usual and Customary" of lower fee determinations from insurance companies.

Financial Responsibility
The undersigned promises to pay all costs of collection, including reasonable attorneys' fees, which may be incurred in the collection of any, and all, indebtedness due to Christie Clinic, P.C. as a result of the undersigned, or one of his family members, receiving healthcare services from Christie Clinic, P.C.

_____ _____
Signature of Patient or Responsible Party Date