

**Prime Immediate and Primary Care
535 Fairway Drive, Suite # 119
Naperville, Illinois 60563
Tel: (630) 857 3967
Fax :(630) 397 4204**

WELCOME TO OUR PRACTICE

This form is designed to acquaint you with our Office Policies. You have the opportunity to question, at this time and prior to service, the Office Policies and Procedures in the following areas of concern. Please initial each item below.

- _____ Policy on Cancellation & Rescheduling (Need 24 hrs)
- _____ Failure to give proper above notice will result in charge of \$15.00
- _____ Policy Explanation of Insurance Benefits & Maximum Coverage
- _____ NSF Checks Recovery (\$20.00) Recovery Fee (There after cash only)
- _____ Insurance Billing (Bills Insurance Company same day of service)
- _____ Patients Statements (We send 1 statement per month)
- _____ Notification of Insurance and / or Job Change (Your Responsibility)
- _____ It is State Law for Parent / Guardian of a child under the age of 18 to remain in the office while the child is being treated
- _____ Medicaid Patients must have their current Insurance Card to be seen

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my doctor and their staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of their staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

My initial above and my signature below signifies that I have read the above and understand the counseling I have received.

Patient Name _____

Patient Address _____

Patient Signature _____ Date _____

Parent / Guardian Signature _____