Dr. Kushner
Marla D. Kushner, DO, FACOFP, FASAM, FSAHM
Family Practice Specializing in Adolescent & Addiction Medicine
2437 N. Southport, Chicago, IL 60614
Phone: (773) 244-9600 • Fax: (773) 248-2348

Welcome to the office of Dr. Marla Kushner

We are looking forward to helping you with your healthcare needs. Please carefully review, initial and sign these policies and procedures.

Basic Biographical Information

Name: First_____ MI____ Last_____

(Circle One) Marital Status: Single Married Partnered Divorced Widowed

Pronouns: He/His___. She /Her____. They/ Them_____ Other: _____

Sex at Birth: _____. Gender Identity: _____

Birthdate: _____/_____/_____ Social Security No. _____-_____-_____

Address: _____

City, State, Zip _____

Occupation: _____

How did you hear about us? _____

Emergency Contact: Name: _____ Phone: _____

Relationship to you: _____

Communication

Please check your preferred contact method below:

☐ Cell phone: _____ ☐ Home Phone: _____

☐ Work phone: _____ ☐ Email: _____

By providing us with the above information, you authorize us to call, leave voicemails, and send text messages using the above information for non-marketing purposes, including appointment reminders, billing and invoice updates and treatment questions. You further understand and agree that communication with us by unencrypted emails and text messages may not be secure.

I acknowledge and agree to this Communication Policy. ___ (initial)

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Insurance Information:

Name: _____

Address:_____

Group#:_____ID: _____

Assignment of Benefits and Release of Information-Financial Agreement:

I hereby give lifetime authorization for payment of insurance benefits be made directly to Marla Kushner, DO and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and any reasonable attorney's fees. I hereby authorize the healthcare provider to release all information necessary to secure the payment of benefits and also authorize the release of any confidential patient information to assist in treatment. I further agree that a photocopy of this agreement shall be valid as the original.

Signature: _____. Date:_____

Printed Name:_____

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Medical History

Name: _____ Date of Birth:_____

Reason for Visit: _____

Are you a smoker Yes ____ No_____

Allergies: _____

Do you have asthma? Yes___ No___

Current Medications and Dosages: _____

_____

Past Illnesses: _____

Past Surgeries: _____

Family History of Medical and Psychiatric Illnesses: _____

Current Symptoms: _____

Last tetanus shot: _____ Do you want a flu shot? Yes or No

Women only: When was your last menstrual period? _____

Last pap smear? _____ Last mammogram?_____

Dr. Kushner is a professor of family Medicine at Midwestern University and teaches medical students and resident physicians. If you object to one of them coming in to the exam room please let the medical assistant know.

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Payment, Cancellation and Late Arrival Policy

Payment Policy

All Co-payments and any past due balances are due at the time of visit. If you receive a bill and would like to make payments, this will need to be arranged with AHS billing at 773-935-4700 prior to your next visit.

Cancellation Policy

As our practice continues to grow, we have updated our cancellation policy in order to better serve our patients. Your appointment time is reserved especially for you. Please call 773-244-9600 at least 24 hours before your scheduled appointment if you will be unable to keep your appointment. This allows Dr. Kushner to offer that appointment to another patient who needs medical care. Conversely, the situation may arise when another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" calendar for the day. **If you do not cancel your appointment at least 24 hours in advance, you will be charged a no-show or late cancellation fee of $100. This fee is not covered by insurance.**

We understand that life gets busy. However, a pattern of missed appointments without proper notice does not show mutual consideration. Patients who fail to provide advanced cancellation for three appointments in the span of one year may be subject to dismissal from the practice.

Late Arrival Policy

We know that delays can happen when you are trying to get to your appointment. However, we must try to keep the other patients and doctors on time. If you arrive 15 minutes past your scheduled appointment time, we may have to reschedule your appointment.

I have read and acknowledge your Payment, Cancellation and Late policies.

_____ _____

Signature Date

_____

Print Name

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PATIENT AGREEMENTS AND AUTHORIZATIONS

CONSENT FOR TREATMENT. I hereby consent to the treatment provided by dr. Marla Kushner and its employees or designees. I authorize the mental and physical health care services deemed necessary or advisable by my caregivers to address my needs. (_____)

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION. I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting the healthcare operations of Dr. Marla Kushner. I authorize Dr. Marla Kushner to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that Dr. Marla Kushner may release objective clinical information related to my diagnosis and treatment, which may be requested, by my insurance company or its designated agent. (_____)

ASSIGNMENT OF INSURANCE BENEFITS/PAYMENT GUARANTEE/ COLLECTION FEE. I authorize payment to be made directly to Dr. Marla Kushner for insurance benefits payable to me. I understand that I am financially responsible to Dr. Marla Kushner for any covered or non-covered services, as defined by my insurer. I understand that if my account balance becomes overdue and the overdue account is referred to a collection agency, I will be responsible for the costs of collection including reasonable attorney fees. (_____)

PRIVACY POLICY. I acknowledge having received Dr. Marla Kushner's. "Notice of Privacy Practices". My rights including the right to see a copy of my record, to limit disclosure of my health information, and to request an amendment to my record, is explained in the Policy. I understand that I may revoke in writing my consent for release of my health care information, except to the extent Dr. Marla Kushner has already made disclosures with my prior consent. (_____)

_____ _____ _____
Patient or Authorized Person Signature Relationship Date

_____ _____
Witness Signature Date