

James E. Wilson, M.D.

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AUTHORIZATION FOR RELEASE OF INFORMATION/MEDICAL RECORDS

I AUTHORIZE DR. JAMES E. WILSON TO RELEASE TO MY INSURANCE CARRIER OR OTHER CATEGORY OF THIRD PARTY PAYOR, MEDICAL REVIEW PROGRAMS/AGENCIES CONTRACTING WITH THIRD PARTY PAYOR, THE SOCIAL SECURITY ADMINISTRATION UNDER TITLE XVIII OF THE SOCIAL SECURITY ACT, OR OTHER INTERMEDIARIES RESPONSIBLE FOR PAYMENT OF MY MEDICAL CHARGES, THE FOLLOWING INFORMATION: DIAGNOSIS AND OTHER MEDICAL INFORMATION FOR THE PURPOSE OF SECURING PAYMENT OF MY MEDICAL TREATMENT. I UNDERSTAND THAT I CAN REVOKE THIS CONSENT AT ANY TIME BY GIVING WRITTEN NOTICE TO DR. JAMES E WILSON. I UNDERSTAND THAT I HAVE THE RIGHT TO INSPECT AND COPY THE INFORMATION TO BE DISCLOSED. I UNDERSTAND THAT IF I REFUSE TO CONSENT TO THIS RELEASE OF INFORMATION, I WILL BE HELD PERSONALLY RESPONSIBLE FOR PAYMENT OF ALL MEDICAL CHARGES RELATED TO THIS TREATMENT. I HEREBY REPRESENT AND WARRANT TO DR. JAMES E. WILSON THAT I HAVE COMPLIED WITH ALL OF THE REQUIREMENTS OF MY MEDICAL INSURANCE CARRIER, OR THE HEALTHCARE SERVICE PROVIDER, PRIOR TO HAVING THE PROCEDURE SET FORTH AT PARAGRAPH 1, INCLUDING OBTAINING ANY PRE-CERTIFICATION OR PERMISSION NECESSARY. IN THE EVENT, I HAVE NOT SO COMPLIED, I EXPRESSLY AGREE TO PAY DR. JAMES E. WILSON ALL CHARGES, FEES AND COSTS NOT PAID BY MY INSURER OR OTHER HEALTHCARE SERVICE PROVIDERS.

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I AUTHORIZE PAYMENT OF ALL MEDICAL BENEFITS TO WHICH I AM OR MAY BE ENTITLED TO BY A PRIVATE OR PUBLIC PAYOR DIRECTLY TO DR. JAMES E. WILSON, M.D. I UNDERSTAND THAT I WILL BE FULLY RESPONSIBLE FOR PAYMENT OF ANY AND ALL CHARGES NOT COVERED BY MEDICAL INSURANCE.

CANCELLATION/NO SHOW POLICY

PLEASE BE ADVISED THAT WHEN YOU SCHEDULE AN APPOINTMENT WITH OUR OFFICES YOU ARE MAKING A RESERVATION WITH A LICENSED PROFESSIONAL. THEREFORE SAME DAY CANCELLATIONS AND NO SHOWS WILL BE SUBJECT TO A \$100.00 FEE PER INCIDENT.

FEES NOT COVERED BY INSURANCE

I HAVE READ AND REVIEWED THE INFORMATION PROVIDED CONCERNING FEES OR PATIENT SERVICES NOT COVERED BY INSURANCE.

PRIVACY PRACTICES ACKNOWLEDGEMENT

I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES AND I HAVE BEEN GIVEN AN OPPORTUNITY TO REVIEW IT.

I HAVE READ AND REVIEWED THE ABOVE INFORMATION:

PATIENT NAME: (PRINT) _____ DATE OF BIRTH: ____/____/____

PATIENT, PARENT OR LEGAL GUARDIAN
SIGNATURE: _____ DATE: _____

WITNESS TO SIGNATURE: _____