WILCOX
FAMILY MEDICINE
Dr. James A. Wilcox

Last Name: _____ ***First Name*:** _____

Date of Birth: _____ ***Sex*** (circle one): M F **Date:** _____

Race (circle one): American Indian Asian Pacific Islander African American Caucasian Hispanic Other

Ethnicity (circle one): Hispanic/Latino Non-Hispanic/Latino Refuse

Address: _____

_____

Phone:

Home: _____ Cell: _____ Work: _____

Email: _____

Employment Status (circle one): Full time Part Time Retired Unemployed Unknown

Current Medications:

Name Dose Frequency

_____
_____
_____
_____
_____

Pharmacy:

Name City State

_____

_____

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HIPPA AUTHORIZATION

I, _____ give permission to Dr. Wilcox to use and disclose my protected health information including medical, treatment and diagnostic records to the following. Please include name and relation to patient.

- _____
- _____
- _____

_____ _____

Signature of Patient or Authorized Representative **Relationship**

_____

Printed Name of Patient or Authorized Representative

_____

Date

Emergency Contact

Please provide us with contact information in case of an emergency:

Name: _____ Ph: _____ Relation: _____

Name: _____ Ph: _____ Relation: _____

Power of Attorney for Health Care Illinois Statutory Short Form

This Power of Attorney revokes all previous Powers of Attorney for Health Care <u>You must sign this form and a witness must also sign it before it is valid.</u>

My name (Print your full name): _____

My address: _____ **I want the following person to be my health care agent:**

(an agent is your personal representative under state and federal law)

Agent name: _____ **Agent phone number** _____

Address: _____ **Please check box if applicable:**

☐ If a guardian of my person is to be appointed, I nominate the agent acting under this power of attorney as guardian.

Successor health care agents (optional):

If the agent I selected is unable or does not want to make health care decisions for me, then I request the person(s) I name below to be my successor health care agent(s). Only one person at a time can serve as my agent (add another page if you want to add more successor agent names).

Successor agent #1 name: _____ **Phone number:** _____

Address: _____ **Successor agent #2 name:**

_____ **Phone number:** _____

Address: _____ **My agent can make health care decisions for me, including:**

- Deciding to accept, withdraw, or decline treatment for any physical or mental condition of mine, including life and-death decisions.
- Agreeing to admit me to or discharge me from any hospital, home, or other institution, including a mental health facility.
- Having complete access to my medical and mental health records, and sharing them with others as needed, including after I die.
- Carrying out the plans I have already made, or, if I have not done so, making decisions about my body or remains, including organ, tissue or whole-body donation, autopsy, cremation, and burial.

The above grant of power is intended to be as broad as possible so that my agent will have the authority to make any decision I could make to obtain or terminate any type of health care, including withdrawal of nutrition and hydration and other life-sustaining measures.

I authorize my agent to (please check any one box):

☐ Make decisions for me only when I cannot make them for myself. The physician(s) taking care of me will determine when I lack this ability.

(If no box is checked, then the box above shall be implemented.) OR

☐ Make decisions for me only when I cannot make them for myself. The physician(s) taking care of me will determine when I lack this ability.

Starting now, for the purposes of assisting me with my health care plans, and decisions, my agent shall have complete access to my medical and mental health records, the authority to share them with others as needed, and the complete ability to communicate with my personal physician(s) and other health care providers, including the ability to require an opinion of my physician as to whether I lack the ability to make decisions for myself. OR

☐ Make decisions for me starting now and continuing after I am no longer able to make them for myself.

While I am still able to make my own decisions, I can still do so if I want to.

Power of Attorney for Health Care Illinois Statutory Short Form

The subject of life-sustaining treatment is of particular importance. Life-sustaining treatments may include tube feedings or fluids through a tube, breathing machines, and CPR. In general, in making decisions concerning life-sustaining treatment, your agent is instructed to consider the relief of suffering, the quality as well as the possible extension of your life, and your previously expressed wishes.

Your agent will weigh the burdens versus benefits of proposed treatments in making decisions on your behalf.

Additional statements concerning the withholding or removal of life-sustaining treatment are described below. These can serve as a guide for your agent when making decisions for you. Ask your physician or health care provider if you have any questions about these statements.

Select only one statement below that best expresses your wishes (**OPTIONAL**)

- ☐ The quality of my life is more important than the length of my life. If I am unconscious and my attending physician believes, in accordance with reasonable medical standards, that I will not wake up or recover my ability to think, communicate with my family and friends, and experience my surroundings, I do not want treatments to prolong my life or delay my death, but I do want treatment or care to make me comfortable and to relieve me of pain.
- ☐ Staying alive is more important to me, no matter how sick I am, how much I am suffering, the cost of the procedures, or how unlikely my chances for recovery are. I want my life to be prolonged to the greatest extent possible in accordance with reasonable medical standards.

Specific limitations to my agent's decision-making authority:

The above grant of power is intended to be as broad as possible so that your agent will have the authority to make any decision you could make to obtain or terminate any type of health care. If you wish to limit the scope of your agent's powers or prescribe special rules or limit the power to authorize autopsy or dispose of remains, you may do so specifically in this form.

_____

_____

_____

_____

_____

_____

My signature: _____ **Today's date:** _____

Have your witness agree to what is written below, and then complete the signature portion:

I am at least 18 years old. (check one of the options below):

- ☐ I saw the principal sign this document, or
- ☐ The principal told me that the signature or mark on the principal signature line is his or hers.

I am not the agent or successor agent(s) named in this document. I am not related to the principal, the agent, or the successor agent(s) by blood, marriage, or adoption. I am not the principal's physician, advanced practice nurse, dentist, pediatric physician, optometrist, psychologist or a relative of one of those individuals. I am not an owner or operator (or relative of an owner or operator) of the health care facility where the principal is a patient or resident.

Witness printed name: _____

Witness address: _____

Witness Signature: _____ **Date Signed:** _____

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OFFICE & FINANCIAL POLICIES:

(Please initial each policy)

____Insurance: The patient, guardian, or parent (if patient is a minor), is responsible for knowing his/her benefit coverage We will file your insurance claim on your behalf. However, we WILL NOT become involved in disputes between you and your insurance company regarding coverage and/or policy benefit criteria. We will supply any information necessary. You are responsible for the timely payment of your account. You are responsible for all non-covered charges and services. We may have you sign a WAIVER OF LIABILITY for any service that we think may not be covered by insurance.

____Self Pay: Payment in full is expected at the time of service.

___Referrals: It is the patient's responsibility to know if referrals are required for specialist's visits and to inform his/her Primary Care Physician. On average, please allow up to 4 business days to process referrals.

____Check-In: Please bring the CURRENT insurance card to EVERY visit to allow for proper and timely claim filing otherwise you will be considered self-pay or asked to reschedule your appointment. You will also be asked at every visit to verify demographic information. If the wrong insurance information is given, you will be charged a $25.00 resubmission fee. Co-Pays, additional fees, and balances are due AT THE TIME OF SERVICE. There is a $20.00 fee for returned checks.

____Late Arrivals: If you arrive to your appointment more than 15 MINUTES past your scheduled time, you will be asked to reschedule.

____No-Shows: Any missed appointments without notification prior to your scheduled time will result in a $50.00 no-show fee.

____Minors: Unaccompanied minors (18 and under) must have a written and signed (by parent or guardian) authorization for medical treatment at the time of check-in.

I have read, understand, and agree to the above office and financial policies.

Patient name: _____ *Date:* _____

Patient/Guardian Signature: _____