Method of Payment: ☐Cash ☐Check
Amount Paid: ☐$60 ☐$90 Other:_____

APPLICATION FOR

COMPASSIONATE CARE NETWORK (CCN)

6348 N. Milwaukee Ave., # 215, Chicago, IL 60646
Tel (773) 775-3600 Fax (888) 226-6363: email info@ccnchicago.com

NOTE: PLEASE PRINT YOUR INFORMATION ON THIS FORM IN CAPITAL LETTERS.

NAME____ **DATE OF BIRTH**______________
Last Name **First Name** **M.I**

SEX M / F____ **AGE**______________

ADDRESS____
Street **Apt., Ste** **City** **State** **Zip**
Code

TELEPHONE: Home:______________ **Work:**______________ **E MAIL**____________________

HEALTH HISTORY

WHAT IS YOUR WEIGHT? _____________ **WHAT IS YOUR HEIGHT?** _____________

HAVE YOU HAD ANY PAST MEDICAL PROBLEMS?

Asthma ____ Cancer ____ Diabetes ____ High Blood Pressure ____ Heart Disease ____ Stroke ____

Any Other Health Problems? ____

HAVE YOU HAD ANY SURGERY IN THE PAST? **No _____ Yes ______**

IF YES DESCRIBE **What** ________________________________ **When** ______________

ARE YOU TAKING ANY MEDICATIONS? **No _____ Yes_____**

DO YOU SMOKE? **No ____ Yes ____If yes how much?** ____________

DO YOU HAVE ANY OTHER HEALTH INSURANCE? **Yes ___ No ___**

PRIMARY CARE PHYSICIAN (PCP) SELECTED:________________________________

Acknowledgements & Declarations: **I declare that I have no health insurance coverage for the services being provided by CCN. I declare that my annual income is below the 400% Federal Poverty Guideline threshold. I acknowledge that all information provided above is accurate to the best of my knowledge. I agree to pay the fee of $25.00 for each office visit to the CCN physician assigned to me. I also understand that lab and x-ray charges will be additional and will be payable by me to the physician's office or to the facility directly. If I need Specialist Consultation and such a consultant is not available within CCN then I will seek a consultant outside the network and will be willing to pay the consultants regular fee. In case of a medical emergency, I agree to seek emergency room care at the nearest hospital facility and will not hold any CCN physician liable for my care. I understand that pregnancy care is not provided by CCN providers. I agree to pay the minimum membership fee of $60.00 for six months (Individual) or $90.00 for six months (Family), to join the network unless otherwise waived. I agree to enroll for six months (initial) and twelve months (subsequent renewals). Make payment to Compassionate Care Network. Mailing address: 6348 N. Milwaukee Ave., #215, Chicago, IL 60646**

Applicant Signature ______________________________ **Date Signed** ____________________