

ADVANCED SURGICAL CARE OF NORTHERN ILLINOIS, LTD.

PLEASE COMPLETE ALL INFORMATION

First Name _____ M.I. _____ Last Name _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Work _____ Cell _____
Birth Date _____ Age _____ Sex _____ SS # _____
Employer _____ Occupation _____
Marital Status S M D W Name _____ Spouse's Daytime Phone _____
Who referred you to our office? _____ Primary Care Physician _____
Reason/symptoms leading to this visit _____
_____ Which side? _____

Are you here regarding a work injury/car accident? Y / N Date of incident _____
If Workers Comp, did you report this? Y / N Name/phone no. of Ins. Co. _____

PRIMARY INSURANCE INFORMATION

Insured _____ Insured Birth Date _____
Employer _____ SS# _____
Insurance Company _____ Copay _____ Type: PPO POS EPO HMO
Group No. _____ ID No. _____ Phone No. _____

SECONDARY INSURANCE INFORMATION

Insured _____ Insured Birth Date _____
Employer _____ SS# _____
Insurance Company _____ Copay _____ Type: PPO POS EPO HMO
Group No. _____ ID No. _____ Phone No. _____

MEDICAL HISTORY

Have you ever had surgery before? Y / N Describe, Date _____

Have you ever had anesthesia? Y / N Did you experience any of the following:
 Airway problem? Malignant hypothermia (High fever during surgery)?
Do you smoke? Y / N How many packs per day? _____ How many years? _____
Do you consume alcohol? Y / N Quantity? _____ How often? _____

Does your medical history include any of the following:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Bronchitis or chronic cough | <input type="checkbox"/> Anemia | <input type="checkbox"/> Stomach Ulcer |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Swelling in hands or feet | <input type="checkbox"/> High blood pressure | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis or jaundice | <input type="checkbox"/> Heart Murmur or rheumatic fever | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Thyroid problem | <input type="checkbox"/> Epilepsy or seizures | <input type="checkbox"/> Kidney problem |
| <input type="checkbox"/> Joint stiffness or Arthritis | <input type="checkbox"/> Coagulation or bleeding problem | <input type="checkbox"/> Back pain or injury | |
| <input type="checkbox"/> Other _____ | | | |

Prescription Medications: None [] _____

Do you have any significant medical history in your family? _____

Do you have any medication allergies or reactions? Y / N Explain _____

Ht. _____ Wt. _____ Are you taking any supplements or over the counter medications? Y / N

Explain: _____

Do you see any medical specialists? Who? _____

Signature _____

Date _____

Advanced Surgical Care

FINANCIAL POLICY

Welcome to our practice. Your health is our primary concern. In order to reduce confusion and misunderstanding between our patients and the practice we have adopted the following financial policy. If you have any questions about the policy; please discuss them with our office manager.

We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Your Insurance

We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. You are responsible for knowing your insurance plan requirements. Some insurance plans require a referral form. It is your responsibility to obtain and bring your referral form at the time of service. We will bill those plans with which we have an agreement and will only require you to pay the authorized copayment at the time of service. It is the policy of our office to collect the copay when you arrive for your appointment.

In the event your health plan determines a service to be "not covered", for any reason, you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

We bill your health plan for all services provided in the hospital. Any balance (unpaid deductible copayment) will be your responsibility and is due upon receipt of a statement from our office.

Minor patients

For all services rendered to minor patients, we will look to the adult accompanying the patient, authorizing treatment, and the parent or guardian with custody, for payment.

In the event that an insurance payment is not received within two months of submission, we would ask that you contact your insurance carrier. In addition, be aware that your coverage is an agreement between you and your insurance company, and that all fees are ultimately your responsibility.

Please Print the Name of the Patient

Signature of Patient or Responsible Party if a Minor

Date

OVER>>>

**Advanced Surgical Care of Northern Illinois, Ltd.
802 Fox Glen
Barrington, Illinois 60010**

Authorization to release Medical Information:

Patient's or Authorized Person's Signature Required:

I authorize the release of any medical or other information necessary to process an insurance claim. I authorize payment of medical benefits directly to: Advanced Surgical Care of Northern Illinois, Ltd.

Signed _____ Date _____

Privacy Practices:

I, _____ have received the Notice of Privacy Practices from Advanced Surgical Care of Northern Illinois, Ltd. on

Date

Signed _____

**Advanced Surgical Care
802 Fox Glen
Barrington, IL 60010**

NOTICE OF PRIVACY PRACTICES

Introduction

We maintain protocols to ensure the security and confidentiality of your personal information. We have physical security in our building, passwords to protect databases, compliance audits, and virus/intrusion detection software. Within our practice, access to your information is limited to those who need it to perform their jobs.

At our practice, we are committed to treating and using protected health information about you responsibly. This Notice of Privacy Policies describes the personal information we collect and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

Understanding your Health Record

Each time you visit our practice, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment.
- Means of communication about the many health professionals who contribute to your care.
- Legal document describing the care you received.
- Means by which you or a third-party payer can certify that services billed were actually provided.
- Tool in educating health professionals.
- Source of data for medical research.
- Source of information for public health officials charged to improve the health of the state and nation.
- Source of data for our planning and marketing
- Tool by which we can assess and continually work to improve the care we render and outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy; better understand who, what, when, where,. And why others may access your health information: and make more informed decisions when authorizing disclosure.

Your Health Information Rights

Although your health record is the physical property of our practice, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of privacy policies upon request
- Inspect and copy your health record as provided by 45 CFR 164.524
- Amend your health record as provided by 45 CFR 164.526
- Obtain an accounting of disclosures of your health information as provided by 45 CFR 164.528.
- Request confidential communications of your health information as provided by 45 CFR 164.528.
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522 (our practice, however, is not required by to agree to a requested restriction).

Our Responsibilities

Our Practice is required to:

- Maintain the privacy of your health information.
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
- Abide by the terms of this notice.
- Notify you if we are unable to agree to a requested restriction.
- Accommodate reasonable requests you may have to communicate your health information.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. We will keep a posted copy of the most current notice in our facility containing the effective date in the top, right-hand corner. In addition, each time you visit our facility for treatment you may obtain a copy of the current notice in effect upon request.

We will not use or disclose your health information in a manner other than that described in the section regarding Examples of Disclosures For Treatment, Payment And Health Operation, without your written authorization, which you may revoke as provided by (45 CFR 164, 508 b 5),

Except to the extent that action has already been taken.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact our practice's Privacy Officer at (847) 381-8161.

If you believe your privacy rights have been violated, you can either file a complaint with our Privacy Office, or with the Office for Civil Rights, U.S. Department of Health and Human Services (OCR). There will be no retaliation for filing a complaint with either our Privacy Office or the OCR. The address for the OCR is as follows:

Office for Civil Rights
 U.S. Department of Health and Human Services
 200 Independence Avenue, S.W. Room 509F .HHH Building
 Washington, D.C. 20201