Advanced SURGICAL CARE of Northern Illinois, LTD.

# PATIENT REGISTRATION FORM

**(Please Print)**

## PATIENT INFORMATION

| | | | |
|---|---|---|---|
| MR. MRS. MISS. MS. PATIENT'S LAST NAME | FIRST | MIDDLE | MARITAL STATUS ***(Circle one):*** SINGLE MARRIED DIVORCED SEPARATED WIDOW |
| IS THIS YOUR LEGAL NAME? YES NO<br>IF NOT, WHAT IS YOUR LEGAL NAME (FORMER NAME)? | | BIRTH DATE / / | AGE / SEX M F |
| STREET ADDRESS: | SOCIAL SECURITY # ***(Last 4 only)*** 000-00- | | HOME PHONE ( ) |
| CITY / STATE / ZIP: | EMAIL: | | CELL PHONE ( ) |
| OCCUPATION: | EMPLOYER: | | WORK PHONE ( ) |

WHO REFERRED YOU TO OUR OFFICE? FAMILY FRIEND CLOSE TO HOME / WORK INTERNET
DR._____ INSURANCE PLAN HOSPITAL OTHER _____

PRIMARY CARE PHYSICIAN NAME AND CITY:

PREFERRED PHARMACY NAME AND CITY:

Race: Caucasian Asian African-American Hispanic Hawaiian/Pacific Islander Prefer not to answer
Ethnicity: Hispanic Non-Hispanic Prefer not to answer

## INSURANCE INFORMATION

| | | |
|---|---|---|
| INSURANCE COMPANY #1 | INSURED'S NAME | INSURED'S BIRTH DATE / / |
| INSURANCE COMPANY #2 | INSURED'S NAME | INSURED'S BIRTH DATE / / |

PERSON RESPONSIBLE FOR THE BILL:

## IN CASE OF EMERGENCY

| | |
|---|---|
| NAME: | HOME PHONE ( ) |
| RELATIONSHIP TO PATIENT: | CELL PHONE ( ) |

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE MY INSURANCE BENEFITS BE PAID DIRECTLY TO THE PHYSICIAN. **I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE.** I ALSO AUTHORIZE ADVANCED SURGICAL CARE OF NORTHERN ILLINOIS TO RELEASE ANY INFORMATION REQUIRED TO PROCESS MY CLAIMS.

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE

Advanced SURGICAL CARE of Northern Illinois, LTD.

Name _____ Date _____

Your answer on this form will help your health care provider better understand your medical concerns and conditions. If you cannot remember specific details, please provide your best guess. Thank You.

Date of Birth:_____ How would you rate your general health? Excellent Good Fair Poor

Main reason for today's visit: _____

Current Height_____ Weight_____ Other concerns:_____

**MEDICAL HISTORY**

Have you ever had anesthesia? Yes No Did you experience any of the following:
Airway problem? Malignant hypothermia (High fever during surgery?) Do you smoke? Yes No Former How many packs per day?_____How many years?_____
Do you consume alcohol? Yes No Quantity?_____How often?_____

Does your medical history include any of the following ***(circle if applicable):***

| | | | |
|---|---|---|---|
| Asthma | Bronchitis | Anemia | Hypertension/High Blood Pressure |
| Heart Attack | Irregular Heart Beat | Emphysema | Stomach Ulcer |
| Mitral Valve Prolapse | Swelling in hands or feet | Chest pain | Joint stiffness or Arthritis |
| Diabetes | Hepatitis or jaundice | Kidney problem | Back pain or injury |
| Thyroid problem | Epilepsy or seizures | Heart Pacemaker (please have card available) | |
| Tuberculosis | Stroke | Cancer (type):_____ | |
| Other (please specify):_____ | | | |

**MEDICATIONS:**

| Medication/Vitamin/Supplement | Dosage/Strength (e.g. mg/pill) | How many times Daily? |
|---|---|---|
| 1 | | |
| 2 | | |
| 3 | | |
| 4 | | |
| 5 | | |
| 6 | | |
| 7 | | |
| 8 | | |

**SURGICAL HISTORY:**

| Surgeries | Year of Surgery | Reason for Surgery |
|---|---|---|
| 1 | | |
| 2 | | |
| 3 | | |
| 4 | | |
| 5 | | |
| 6 | | |
| 7 | | |
| 8 | | |

**FAMILY HISTORY:**

| **Check all that apply** | **MOTHER** | **FATHER** | **OTHER RELATIVES** (please specify) |
|---|---|---|---|
| Cancer (please specify) | | | |
| Heart Disease | | | |
| Diabetes | | | |
| Stroke | | | |
| Hypertension (high blood pressure) | | | |
| Other (please specify) | | | |

**ALLERGIES:** Do you have allergies or reactions to:

| **Medications** | **Reaction** | **Foods** | **Reaction** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Advanced SURGICAL CARE of Northern Illinois, LTD.

# WOMEN'S HEALTH HISTORY

This questionnaire is designed to help us obtain a complete patient history and identify any problem area which will assist the doctor in making a diagnosis. Your cooperation is greatly appreciated.

Birth Date:_____ Age:_____

Patient name:_____

1. Any previous x-ray examination of the breast? Yes No If yes: where, when, and results, if known?

_____

2. At what age did you begin menstruation?_____Stop menstruation? _____

3. What was the date of your last menstrual period? _____

4. Do you have any children? Yes No If yes: How many? ____ Age at first pregnancy? _____

5. Were your children breast fed? Yes No If yes: Currently? Yes No

6. Have you ever had any of the following on either breast?

| **Check all that apply** | Yes | No | Right | Left | Now |
|---|---|---|---|---|---|
| Discharge | | | | | |
| Pain | | | | | |
| Mastectomy | | | | | |
| Biopsy | | | | | |
| Enlargement | | | | | |
| Surgery | | | | | |
| Injections | | | | | |
| Lump | | | | | |

7. Is there a history of breast cancer in your family? Yes No If yes: Whom? What age at diagnosis?

| Family member | Age diagnosed |
|---|---|
| | |
| | |
| | |

9. Coffee, tea, cola drinks, or chocolate usage per day: _____

10. Other complaints: _____

# PAYMENT AND PRIVACY POLICIES
## Advanced Surgical Care of Northern Illinois, Ltd

Thank you for choosing Advanced Surgical Care of Northern Illinois for your surgical needs. We are committed to providing you with quality health care and we would like you to completely understand our payment policy. A copy of our payment policy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans. If you are not insured by a plan, we do business with, payment in full is expected at each visit. If you are insured by a plan, we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Due to the many different insurance products available, our staff cannot guarantee your eligibility and coverage. Please be sure to check with your insurer's member benefits department about services and providers covered prior to your appointment. Many websites have erroneous information and are not a guarantee of coverage. You are responsible for requesting and obtaining a properly dated referral if required by your insurer and are responsible for payment if your claim is rejected for a lack of one.

2. **Co-payments** and deductibles. Payment is expected at the time of your visit. All co-payments, unmet deductibles, co-insurance, or charges not covered by your insurance must be paid at the time of service. This arrangement is part of your contract with your insurance company. Please help us in upholding the law by paying these at each visit. We will accept cash, check, or credit card.

3. **Surgical Deposit**. Advanced Surgical Care will collect a surgical deposit which will be due 3 weeks prior to your procedure. This is procedure specific and will be discussed with you when scheduling your procedure.

4. **Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reason

5. **Proof of insurance.** All patients must complete our patient information form before seeing a provider. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

6. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

7. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

8. **Nonpayment.** If your account has a balance after your insurance has paid their portion, you will receive a letter stating that you have 30 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Patients consent to receive phone calls and/or text messages, in compliance with HIPAA, to collect past due balances and/or marketing messages. Please be aware that if a balance remains unpaid, after 30 days, we will charge your card on file for your balance in full.

9. **Returned checks** will incur a $30.00 service charge. You will be asked to bring cash or certified funds to cover the amount of the check plus the $30 service charge to pay the balance prior to receiving services from our staff or providers. Stop payments constitute a breach of payment and are subject to the $30 service fee and collections action. All bad checks written to this office are subject to collections.

10. **Billing office.** If you have questions regarding any of our billing statements, our billing company can be contacted at.847-381-8161 option 5.

11. **Your Medical Information:Your rights-Our responsibilities:** Your privacy is important to us. Please inform the staff if you need another copy or have not received our privacy policy

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines.

_____ _____

Signature of Patient/Responsible Party Date

Advanced
SURGICAL CARE
of Northern Illinois, LTD.

# Advanced Surgical Care of Northern Illinois

# APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to Advanced Surgical Care. When you schedule an appointment with Advanced Surgical Care, we set aside enough time to provide you with the highest quality care. Should you need to cancel or rescheduled an appointment, please contact our office as soon as possible. This should be done no later than 24 hours prior to your scheduled appointment. If you are running late, please notify the office. If a patient arrives more than **10 minutes** past their scheduled time, our office staff will need to reschedule your appointment and our no-show policy terms will apply.

**Effective January 1, 2025,** any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least 24-hour notice will be considered a No Show and charged a **$50.00 fee**.

- Any established patient who fails to show or cancels/reschedules an appointment without 24-hour notice a **second time** will be charged a **$60.00 fee**.

- If a **third** No Show or cancellation/reschedule without 24-hour notice should occur with a year's time, the patient may be **dismissed from Advanced Surgical Care.**

- Any new patient who fails to show for their initial visit will not be rescheduled.

- These fees are the responsibility of the patient, not the insurance company, and are **due prior to the patient's next office visit.**

We understand there may be times when an unforeseen emergency may occur, and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact our Office Manager, who may be able to waive the No Show fee. You may contact Advanced Surgical Care during regularly scheduled office hours at the numbers below. Voicemail messages can be left, and we will attempt to call you back once received. Given the sometimes-unreliable nature of voicemail, cancellation of an appointment is not official until the patient has spoken directly with one of our staff members. We will also accept appointment cancellations via our Live Well portal.

***Advanced Surgical Care 847-381-8161***

I have read Advanced Surgical Care's Cancellation/No Show Policy and agree to its terms. I understand that these terms are renewable each year and do not require additional signatures in subsequent years. A paper copy of this policy is available upon request.

_____ _____ _____

**Signature** **Name** **Date**

Advanced
SURGICAL CARE
of Northern Illinois, LTD.

# CONSENT FOR RELEASE OF HEALTH INFORMATION

Patient name: _____

Date of Birth: _____

| Please specify if we can leave you a detailed message (circle one): | |
|---|---|
| Leave Detailed Message<br><br>Yes No | Leave Detailed Lab/Test Results<br><br>Yes No |

*Answering machines and voice mail must have an identifying message to confirm these are your numbers for example; "You have reached John Doe"

Please list any persons with whom we **MAY** share details about your health care. Indicate below whether this may include **sensitive health information (SHI)** such as mental health, developmental disabilities, AIDS/HIV, Drug/Alcohol treatment and or Genetic testing.

I understand that this consent is valid until it is revoked by me and applies to information about me obtained through all Advanced Surgical Care locations and Physicians. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

| Name | Relationship | Release SHI? (circle one) |
|---|---|---|
| | | Yes No |
| | | Yes No |
| | | Yes No |
| | | Yes No |

**Signature of Patient** or Responsible Party if a minor:_____

Date: _____