KANE CENTER
for Advanced Metabolic & Bariatric Surgery

1-866-716-KANE (5263)

SUBURBAN SURGICAL CARE SPECIALISTS, S.C.

WELCOME TO OUR KANE CENTER SEMINAR FOR WEIGHT LOSS SURGERY

PLEASE MAIL THE COMPLETED PACKET TO:

4885 HOFFMAN BLVD., SUITE 400
HOFFMAN ESTATES, IL 60192

IN THE ENVELOPE PROVIDED.

WE MUST RECEIVE YOUR COMPLETED DOCUMENTS AT LEAST 5 DAYS PRIOR TO YOUR CONSULTATION.

THIS ALLOWS US TO VERIFY YOUR INSURANCE BENEFITS AHEAD OF TIME.

IT IS IN YOUR BEST INTEREST TO **VERIFY** YOUR INSURANCE BENEFITS FOR BARIATRIC SURGERY PRIOR TO YOUR CONSULTATION APPOINTMENT.

IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT US AT:
(866) 716-KANE (5263)

THANK YOU

WE LOOK FORWARD TO WORKING WITH YOU IN YOUR WEIGHT LOSS JOURNEY.

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INSURANCE INFORMATION FORM

PATIENT INFORMATION

CIRCLE ONE ⇨

Male Female Transgender

Single Separated

Married Divorced Widowed

Name

Birth Date

Age

Address

E-Mail Address

City/State/Zip

Home #

Work #

Cell #

PATIENT EMPLOYER

Company

Address

City/State/Zip

Telephone #

Extension

ATTACH COPY/FRONT AND BACK OF INSURANCE CARD

Is this the primary policy? ___ Yes ___ No

PRIMARY INSURANCE INFORMATION

Insurance Company

Address

City/State/Zip

ID#

Group #

Telephone #

Office Visit Copay Amount $

Relationship to Insured

SPOUSE'S EMPLOYER/SECONDARY INSURANCE INFORMATION

Relationship to Insured

Name

Date of Birth

Company

Address

City/State/Zip

ATTACH COPY/FRONT AND BACK OF INSURANCE CARD

Insurance Company

Address

City/State/Zip

ID#

Group #

Telephone #

Is this the primary policy? ___ Yes ___ No

EMERGENCY CONTACT

Name

Phone #

Primary Care Physician Name

Address

Phone #

KANE CENTER
for Advanced Metabolic & Bariatric Surgery

SUBURBAN SURGICAL CARE SPECIALISTS, S.C.

KANE CENTER

Prairie Pointe Medical
4885 Hoffman Boulevard, Suite 400
Hoffman Estates, Illinois 60192
PHONE: 866-716-KANE (5263)
FAX: 847-255-3206

TO:

PERSON AND/OR INSTITUTION _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ FAX _____

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

PATIENT NAME _____ DOB _____

ADDRESS _____

I hereby authorize that the protected health information regarding the above named person be forwarded to the following doctor at Suburban Surgical Care Specialists, S.C.

James M. Kane, Jr., M.D., F.A.C.S., F.A.S.M.B.S.
Paul J. Guske, M.D., F.A.C.S., F.A.S.M.B.S.
Peter C. Rantis, Jr., M.D., F.A.C.S., F.A.S.C.R.S., F.A.S.M.B.S.
Jonathan W. Wallace, M.D., F.A.C.S., F.A.S.M.B.S.

Any records of examination and treatment rendered to me during the period (dates) from _____ to _____

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Legal Guardian (Required if patient is not legally authorized to sign) Relationship to Patient

_____
Witness

REDISCLOSURE: Notice is hereby given to the patient or legal representative signing the authorization that we cannot guarantee that the recipient receiving the requested health information will not redisclose any or all of it to others. Notice is hereby given to the recipient that law prohibits the redisclosure of any health information regarding drug and/or alcohol abuse, HIV and mental health treatment.

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SUBURBAN SURGICAL
CARE SPECIALISTS, S.C.

RELEASE OF INFORMATION CONSENT

I, _____ , agree to release the initial psychological evaluation report to The Kane Center. I am aware that this one-to-one evaluation and MMPI-II test results will be used to determine my appropriateness for surgery. I also understand that the confidential nature of this information will be protected and that a copy will be retained in my medical file.

_____ _____

(Please Print) Patient's Name Date

_____

Patient's Signature

Patient Name _____ *Date* _____

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(PLEASE CHECK ONE ONLY)
PROCEDURE REQUESTED:

- ☐ **GASTRIC BYPASS**
- ☐ **ADJUSTABLE LAP BAND**
- ☐ **SLEEVE GASTRECTOMY**
- ☐ **DUODENAL SWITCH**

DATE RECEIVED PAPERWORK _____

MEDICAL HISTORY

_____ ____ _____ _____
LAST NAME FIRST AGE HEIGHT (Ft/In) WEIGHT

_____ _____ _____
OCCUPATION DATE OF BIRTH HOW LONG AT CURRENT WEIGHT

MARITAL STATUS ___Married ___Single ___Widowed ___Divorced ___ Separated
RACE ___White ___Black ___Asian ___Native American ___Hispanic
GENDER ___Female ___Male ___Transgender

PRIMARY HEALTH CARE PROVIDER

PHYSICIAN NAME_____
ADDRESS_____
CITY _____ STATE_____ ZIP_____

PHONE_____ FAX_____

How long has this doctor provided medical care for you? _____Months _____ Years
Conditions treated_____

If you are under the care of other physicians, please explain_____

WHO IS THE FIRST PERSON TO NOTIFY IMMEDIATELY FOLLOWING SURGERY?

NAME_____

RELATIONSHIP_____

PHONE (Check where to call) ___Home #_____ ___Work #_____
Will this person be waiting at the hospital during your surgery? ___Yes ___No

SLEEP STUDY DISCLOSURE

You may be required to obtain a sleep study and you may be referred to a Merit Sleep Center for this test. Our practice has a financial interest in some Merit Sleep Centers, however you may opt to obtain this service elsewhere.

*Patient Signature*_____ *Date*_____

How long have you been overweight? _____

Age of first diet? _____

Greatest single weight loss? _____(Number of pounds)

How was your weight loss obtained? _____

How many times have you lost 25 pounds? _____

Favorite foods? _____

Are you a snacker? ___Yes ___No

Favorite snacks? _____

Do you eat a lot of sweets? ___Yes ___No

How often do you eat sweets? _____

Favorite sweets? _____

Are you currently under a physician's care for weight loss? ___Yes ___No

If yes, type of program? _____

Physician Name _____

Address _____

Phone # _____

**********DIETARY HISTORY**********

PLEASE COMPLETE THE FORM AS DETAILED AS POSSIBLE

DIET PROGRAMS	START DATE	END DATE	DURATION OF TIME ON DIET	START WEIGHT	END WEIGHT	# OF POUNDS LOST OR GAINED
M.D. SUPERVISED						
___Medi-Fast	_____	_____	_____	_____	_____	_____
M.D. Name/Address _____						
___Opti-Fast	_____	_____	_____	_____	_____	_____
M.D. Name/Address _____						
___Mayo Clinic	_____	_____	_____	_____	_____	_____
___HMR	_____	_____	_____	_____	_____	_____
___Other	_____	_____	_____	_____	_____	_____
SHOTS ___B-6	_____	_____	_____	_____	_____	_____
___B-12	_____	_____	_____	_____	_____	_____
___Other	_____	_____	_____	_____	_____	_____
M.D. Name/Address _____						

*Patient Name*_____ *Date*_____

DIET PROGRAMS	START DATE	END DATE	DURATION OF TIME ON DIET	START WEIGHT	END WEIGHT	# OF POUNDS LOST OR GAINED
M.D. SUPERVISED						
PILLS						
___Phen-Fen						
___Phentermine						
___Fastin						
___Redux						
___Meridia						
___Xenical						
___Other						
M.D. Name/Address						
NON M.D. SUPERVISED						
___Weight Watchers						
___Nutri-Systems						
___Jenny Craig						
___Diet Center						
___TOPS						
___Overeaters Anonymous						
___Slimfast						
___Sweet Success						
___Other						
MISCELLANEOUS DIETS						
___Low Calorie Diet						
___Low fat Diet						
___High Protein Diet						
___Self Imposed Fasts						
___Atkins Diet						
___Scarsdale Diet						
___Pritikin Diet						
___Richard Simmons						
___Susan Powter						
___Herbal Life						
___Cambridge Diet						
___Other						

*Patient Name*_____ *Date*_____

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SUBURBAN SURGICAL CARE SPECIALISTS, S.C.

DIET PROGRAMS	START DATE	END DATE	DURATION OF TIME ON DIET	START WEIGHT	END WEIGHT	# OF POUNDS LOST OR GAINED
DIET PILLS (Over the counter)						
___Accutrim						
___Dexatrim						
___Metabolife						
___Other						
OTHER TYPES OF WEIGHT LOSS						
___Psychotherapy						
___Acupuncture						
___Hypnosis						
___Subliminal Tapes						
___Other						
EXERCISE						
___Health Club						
___VCR Tapes						
___Other						

FAMILY HISTORY

Check all that apply.

Immediate Family/ Other Family Members (Maternal/Paternal)	Cause of Death	Obese?	Cancer (Type)	Diabetes	Heart Problems (Type)	High Blood Pressure	Arthritis (Type) (Osteo, rheumatoid)	Back Problems

*Patient Name*_____ *Date*_____

MEDICATIONS

List current medications, including vitamins, over-the-counter medications and intermittently used drugs.

DRUG NAME	STRENGTH	TAKEN - HOW OFTEN	PURPOSE	TAKEN - HOW LONG

Are you allergic to any medications or food? ___Yes ___No

Please explain and list_____

Are you allergic to latex? ___Yes ___No

LIST ANY MAJOR ILLNESSES

ILLNESS	DATE	TREATMENT	OUTCOME

LIST ANY SURGERIES

SURGERY	DATE	REASON	OUTCOME

Have you ever had surgery to aid in weight loss? ___Yes ___No

If yes, what procedure?_____ When?_____

*Patient Name*_____ *Date*_____

SOCIAL HISTORY

Have you used tobacco products in the past? ___Yes ___No If yes, how long? _____
Do you use any tobacco products today? ___Yes ___No How many per day? _____
Do you drink alcohol? ___Yes ___No _____
If yes, what beverages? _____How many drinks per day? _____
Do you use caffeine? (coffee, cocoa, colas, chocolates, No-Doz, Aqua Ban) ___Yes ___ No
If yes, in what form? _____How much per day? _____
Are you presently married? ___Yes ___No How long? _____
Do you have children? ___Yes ___No Ages? _____
Are you currently employed? ___Yes ___No How long? _____
On a scale of 1 to 5 (1=least happy), how happy are you with your job? _____
On a scale of 1 to 5, how happy are you with yourself? _____

SHORTNESS OF BREATH AND EXERCISE

Do you experience shortness of breath with physical activity? ___Yes ___No
How long have you been aware of this? _____Months _____Years
When walking stairs, how many steps can you climb before noticing shortness of breath? ____ Steps
Do you exercise regularly? ___Yes ___No
If yes, complete the following questions:
What type of exercise? _____ How often? _____
What prevents you from exercising now? _____
Do you experience chest pain with exercise or activity? ___Yes ___No
What do you take to relieve the pain? _____

ASTHMA AND ALLERGIES

Do you have asthma? ___Yes ___No How long? _____
Do you use an inhaler? ___Yes ___No How long? _____
MEDICATIONS: _____
Do you have allergies? ___Yes ___No Type? _____ How long? _____
MEDICATIONS: _____

SWELLING AND CIRCULATION

Do you experience swelling of the ankles? ___Yes ___No How long? _____
Do you have poor circulation? ___Yes ___No Where? _____
What do you do to decrease swelling? _____

*Patient Name*_____ *Date* _____

THYROID

Thyroid problems? ___Yes ___No How long?_____

Explain _____

MEDICATIONS: _____

DIABETES

Are you diabetic? ___Yes ___No How long?_____

Do you monitor your blood sugar? ___Yes ___No How often?_____

MEDICATIONS: _____

HIGH BLOOD PRESSURE

Do you have high blood pressure? ___Yes ___No How long?_____

MEDICATIONS: _____

CHOLESTEROL

Do you have elevated cholesterol? ___Yes ___No How long?_____

MEDICATIONS: _____

HEARTBURN AND INDIGESTION

Do you suffer from acid reflux? ___Yes ___No How long?_____

MEDICATIONS: _____

Do you suffer from heartburn? ___Yes ___No How long?_____

MEDICATIONS: _____

What foods or drinks cause digestive problems?_____

Do you have pain in your abdomen? ___Yes ___No If yes, provide details_____

_____

Type of pain (sharp, dull, hot, cold, aching, crushing)_____

When does the pain begin (before, during or after eating)_____

How long does it last?_____How often does this happen?_____

Any changes in bowel movements? ___Yes ___No Explain_____

Bloody stools? ___Yes ___No

History of hemorrhoids? ___Yes ___No External or Internal

Have you had a colonoscopy? ___Yes ___No Date_____

Why did you have it performed?_____

*Patient Name*_____ *Date*_____

PSYCHIATRIC HISTORY

Psychiatric Treatment? ___Yes ___No Treated by ___ Psychiatrist ___ Therapist ___ Psychologist

Hospitalization? ___Yes ___No Are you currently being treated? ___ Yes ___ No

When was your treatment?_____ Where?_____

Diagnosis?_____Reason for treatment?_____

Current medications and dosages_____

Do you feel that you are depressed? ___ Yes ___ No Why?_____

BONE OR JOINT PROBLEMS Do you have any of the following: Check all that apply.

LOCATIONS	OSTEOARTHRITIS/ RHEUMATOID	SWELLING	PAIN	STIFFNESS	POPPING
ANKLES					
KNEES					
HIPS					
BACK					
OTHER					

Have you ever been told you have degenerative changes or early arthritic changes in your joints?

___Yes ___No

Have you ever been treated for bone or joint problems or injuries?

Give details, including physical therapy and chiropractic.

DOCTOR	TREATMENT DATE	DIAGNOSIS / TREATMENT
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you taken any medication for these problems? ___ Yes ___ No

List medications_____

_____

What medications are you taking currently for bone/joint problems_____

_____

*Patient Name*_____ *Date*_____

SLEEPING PATTERNS

In what position do you sleep? ___Sitting up ___Lying flat on back
___Lying on side ___Lying on stomach

How many pillows do you use under your head?_____

How many times a night do you wake up?_____

Do you snore? ___Yes ___No

Do you awaken from sleep to catch your breath? ___Yes ___No

Do you ever stop breathing while sleeping? ___Yes ___No

Do you experience daytime fatigue? ___Yes ___No

Do you experience frequent headaches from lack of sleep? ___Yes ___No

Do you doze off during conversations with people? ___Yes ___No

Have you ever had a sleep study done? ___Yes ___No

Have you ever been diagnosed with sleep apnea? ___Yes ___No

Are you using a sleeping device? If yes, what?_____

Which doctor prescribed this device?_____

NEUROLOGIC REVIEW

Do you or have you experienced any of the following?

Seizures ___Yes ___No Explain_____

Vision Changes ___Yes ___No Explain_____

Weakness ___Yes ___No Explain_____

Numbness/Tingling ___Yes ___No Explain_____

Problems Walking ___Yes ___No Explain_____

Headaches ___Yes ___No Explain_____

CARDIAC REVIEW

Do you or have you experienced any of the following:

Chest Pain ___Yes ___No Explain_____

Palpitations ___Yes ___No Explain_____

Heart Attacks ___Yes ___No Explain_____

Arythmias ___Yes ___No Explain_____

Heart Failure ___Yes ___No Explain_____

Date of last EKG?_____

Cardiologist's Name_____ Phone #_____

*Patient Name*_____ *Date*_____

REVIEW OF SYMPTOMS

Unless otherwise specified, answer the following questions referring to your current status.

	YES	NO	COMMENTS
Frequent fatigue and weakness	___	___	_____
Fever, chills or night sweats	___	___	_____
Frequent or severe headaches	___	___	_____
Chronic sinus congestion	___	___	_____
Wheezing	___	___	_____
Heart Murmur	___	___	_____
Anemia	___	___	_____
Convulsions and seizures	___	___	_____
Paralysis	___	___	_____
Numbness or tingling	___	___	_____
Memory loss	___	___	_____
Depression	___	___	_____
Anxiety or mood swings	___	___	_____
Sleep problems	___	___	_____
Drug or alcohol abuse	___	___	_____

*Patient Name*_____ *Date*_____

MENSTRUAL HISTORY (FEMALES)

At what age did your periods start?_____

Are your periods _____ Regular _____ Irregular How long have your periods been irregular?

_____

Are you on medication of irregular periods? ___ Yes ___ No What?_____

What was the date of your last menstrual period?_____

Heavy bleeding? ___Yes ___ No Cramping? ___ Yes ___ No

Spotting between periods? ___Yes ___ No

Have you gone through menopause? ___Yes ___ No If yes, at what age?_____

Have you undergone a hysterectomy? ___Yes ___ No If yes, when?_____

Have you ever been pregnant? ___Yes ___ No Miscarriages? ___ Yes ___ No

Are you currently pregnant? ___Yes ___ No

Do you suffer from infertility problems? ___Yes ___ No

Are you currently being treated for this problem and if so, what is the treatment?_____

_____

Date of last Pap smear_____ Was it normal? ___Yes ___ No

Date of last mammogram_____ Was it normal? ___Yes ___ No

URINARY PROBLEMS (FEMALES)

Do you ever involuntary lose your urine? ___Yes ___ No If yes, what causes this?

___ Coughing ___ Jumping ___ Sneezing ___ Walking ___ Bending ___ Laughing

Do you experience pain with urination? ___Yes ___ No

Do you wear pads for protection? ___Yes ___ No

How often do you change pads?_____

How often do you wet your clothing?_____

Any history of bladder surgery?_____ When/Type_____

*Patient Name*_____ *Date*_____

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TODAY'S DATE: _____ /_____ /_____

PATIENT DEMOGRAPHICS

Patient Name: _____ Birth Date: _____/_____/_____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell: (_____) _____ Work Phone: (_____) _____ Home Phone: (_____) _____

E-Mail Address: _____

Marital Status: _____ Married _____ Divorced _____ Single _____ Widowed

Employed By: _____

Referred By: _____ Primary Care Physician: _____

Pharmacy: _____ Cross Streets: _____ City: _____

HEALTHCARE REFORM QUESTIONS

DUE TO RECENT REFORMS MANDATED BY THE GOVERNMENT, DOCTORS ARE REQUIRED TO ASK ALL PATIENTS FOR THEIR RACE AND ETHNICITY REGARDLESS OF YOUR INSURANCE TO MEET MEANINGFUL USE REQUIREMENTS.

Ethnicity: ___ Non-Hispanic ___ Hispanic ___ Refused to Report

Primary Race: ___ White ___ Hispanic ___ Black or African American ___ American Indian ___ Asian ___ Native Hawaiian ___ Other Pacific Islander ___ Other Race ___ Unreported ___ Refused to Report

LANGUAGE:

___ English

___ Spanish

___ Indian-Hindi

___ Russian ___ Other

PRIMARY INSURANCE COMPANY:

_____

Insured Name: _____

Insured Birth Date: _____ / _____ / _____

ID# _____ **GROUP #** _____

Please provide card(s) to receptionist to scan

SECONDARY INSURANCE COMPANY:

_____

Insured Name: _____

Insured Birth Date: _____ / _____ / _____

ID# _____ **GROUP #** _____

_____ **I Have No Insurance**

IF YOUR VISIT IS RELATED TO AN INJURY, CHECK THE APPROPRIATE RESPONSE IN THE BOX BELOW.
IF IT IS <u>NOT</u> RELATED TO AN INJURY <u>SKIP</u> THIS BOX.

Worker's Comp Carrier Name: _____ Claim # _____

Address: _____ City: _____ State: _____ Zip: _____

Adjuster's Name: _____ Phone: (_____) _____

The injury is due to: ☐ car accident ☐ work injury Date on onset/injury _____ / _____ / _____

Is legal action/litigation pending due to this injury? ☐ Yes ☐ No

Person to contact in an emergency: _____

Cell: (_____) _____ Home Phone: (_____) _____ Work Phone: (_____) _____

ASSIGNMENT OF BENEFITS: I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including MEDICARE, private insurance, and any other health plans to: Suburban Surgical Care Specialists, S.C. The assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment. In the event that I fail to make payment or there is an outstanding obligation on the account, I hereby agree to be responsible for any and all collection costs, court costs and reasonable attorney fees in regards to the collection of this account.

Signed: _____ Date: _____

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RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, _____ , have been asked if I would like to receive a copy of Suburban Surgical Care Specialist's Notice of Privacy Practices. If I have not accepted a copy, I acknowledge that I may ask for a copy of the Privacy Practices at any time during care or after care. By signing this consent, you are also agreeing that Suburban Surgical Care/Kane Center can request your prescription medication history from other healthcare providers for treatment purposes.

Understanding the above, I hereby provide informed consent to Suburban Surgical Care/Kane Center to enroll me in the ePrescribe Program.

Do we have permission to leave medical information on your answering machine?

☐ Yes ☐ No Home Phone# (_____) _____

☐ Yes ☐ No Work Phone# (_____) _____

☐ Yes ☐ No Cell Phone# (_____) _____

Do we have permission to discuss personal medical care/information with other individuals? Check all that apply.

☐ Yes ☐ No Spouse Name _____ Phone# (_____) _____

☐ Yes ☐ No Children Name(s) _____ Phone# (_____) _____

_____ Phone# (_____) _____

☐ Yes ☐ No Parent Name(s) _____ Phone# (_____) _____

_____ Phone# (_____) _____

☐ Yes ☐ No Grandparent Name(s) _____ Phone# (_____) _____

_____ Phone# (_____) _____

☐ Yes ☐ No Other _____ Phone# (_____) _____

_____ _____

(Signature of Patient) (Date)

Suburban Surgical Care Specialists, S.C. Financial Policy

Thank you for choosing Suburban Surgical Care Specialists, S.C. (SSCS). We will work hard to provide the highest quality of care.

Your clear understanding of our Financial Policy is important to our professional relationship. If you have any questions, please contact our Billing Department at 847-255-9697.

The patient, parent or legal guardian, is always responsible for payment. In consideration of services to be rendered, you, as the undersigned patient, parent or guarantor, as applicable, agree to pay SSCS for all services and supplies provided to you (or the patient) at the established rates, including any deductibles, co-payments, coinsurances, non-covered services or any other charges as permitted by third party payors. By signing this Financial Policy you accept responsibility for any costs, including attorney or collection fees incurred by SSCS for the collection of charges for examinations, diagnosis, or treatment provided. Prior to services being rendered you must furnish SSCS with accurate insurance information. For your convenience we accept cash, checks, VISA, MasterCard, and Discover.

Self Pay – all self pay patients are required to pay for services at time of visit or prior to procedure.

Medicare: SSCS accepts Medicare assignment. As a Medicare patient, for covered services, you are responsible for the deductibles and co-insurance amounts as determined by Medicare. If you have supplemental insurance, we will bill the secondary carrier for you. If you do not have supplemental insurance the coinsurance and/or any unmet deductible may be due at time of service. Once claims are processed, you will receive a statement for any outstanding patient responsibility. If SSCS believes because of your circumstances, your care will not be covered by Medicare, an Advanced Beneficiary Notice will be presented to you. In such case Payment will be due at time of service.

Managed Care – As owner of the policy you are responsible for verifying that we are an in-network provider under your plan. HMO members are responsible for obtaining required referrals. If you do not have the required referral you may be rescheduled and/or be responsible for some or all of the charges your insurance does not cover. All copayments or other payments required by your plan to be paid by the patient are required to be paid at the time of service.

Insurance –Please keep in mind, your insurance policy is a contract between you and your insurance company. You are ultimately responsible for all charges incurred. **You must provide us with current and correct insurance information.** You must notify SSCS immediately regarding any changes in insurance. All applicable copayments are due at time of service. If you are unable to pay copay at time of service, your appointment may be rescheduled.

SSCS will file your claim with your insurance company. Prior to services being rendered, SSCS may conduct insurance verification and provide you with the estimated patient responsibility portion of the overall charges. SSCS may require you to pay some or all of the estimated patient responsibility prior to services being rendered. Because your insurance carrier can only provide SSCS with an estimate of patient responsibility portion of the overall charges, once the claim has been processed, there may be additional amounts due from the patient. You will receive a statement for the additional balance due. If claims processing results in a credit balance on your account a refund will be processed within 30 days.

Form Fees: FMLA forms $35 each

Account Statements: Statements are mailed monthly to patients that have an outstanding patient balance due on their account. Payment is expected upon receipt of statement. Any payment arrangement must be discussed and approved by our Billing Department. Overdue accounts may be referred to a collection agency.

Non-Sufficient Funds (NSF) – Returned check fee $35

No Show Fee - $35 for Office visit, $250 for scheduled procedures. Cancellations must be made within 24 hours of appointment time.

Collections – In event of non-payment SSCS shall be entitled to recover all collection expenses, including court costs and reasonable attorney fees, incurred for purpose of obtaining payment of the amount due. If your account is sent to a collections agency or we are listed in a bankruptcy suit you may be dismissed as a patient from our practice at your physician's discretion.

_____

Patient Name

_____

Patient, Parent or Guardian Signature Date