Suburban Surgical Care Specialists, S.C.

James M. Kane, Jr., MD, FACS, FASMBS Peter C. Rantis, Jr., MD, FACS, FASCRS, FASMBS
Paul J. Guske, MD, FACS, FASMBS Jonathan W. Wallace, MD, FACS, FASMBS

PATIENT MEDICATION LIST

PATIENT NAME:_____Date of Birth:____/____/____Date:_____

Medications you are taking (including over the counter supplements example: vitamins)

Medications:	Strength:	How Many times a day:

Do you take aspirin? ☐ Yes ☐ No

Allergies: (please list)

_____

_____

Bone Density: Date:_____ Location:_____

Mammogram: Date:_____ Location:_____

Colonoscopy: Date:_____ Location:_____

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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: _____ Social Security # _____/_____ /_____

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 NOT RELATED TO AN INJURY SKIP 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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Patient Name:_____ Date: _____/_____/_____

HISTORY OF PRESENT ILLNESS:

Purpose of this visit:_____

What symptoms are you having? For how long?_____

_____

MEDICAL HISTORY: (Such as High Blood Pressure; Cancer; Diabetes; High Cholesterol)

_____ _____

_____ _____

_____ _____

SURGICAL/HOSPITALIZATION HISTORY: Complications? Problems w/anesthesia?
Date of surgery or hospitalization

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

SOCIAL HISTORY: **Occupation:**_____

Cigarettes or tobacco: _____Yes _____No How much/how often? _____

Alcohol _____Yes _____No How much/how often? _____

Drugs _____Yes _____No How much/how often? _____

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	Yes	No
GENERAL		
Good general health lately	☐	☐
Recent weight change	☐	☐
Fever	☐	☐
Fatigue	☐	☐
Headaches	☐	☐
EYES		
Eye disease or injury	☐	☐
Wear glasses/contact lenses	☐	☐
Blurred or double vision	☐	☐
EAR, NOSE, MOUTH, THROAT		
Hearing loss or ringing	☐	☐
Earaches or drainage	☐	☐
Chronic sinus problems	☐	☐
Nose bleeds	☐	☐
Bleeding gums	☐	☐
Bad breath or bad taste in mouth	☐	☐
Sore throat	☐	☐
Laryngitis	☐	☐
Swollen glands in neck	☐	☐
CARDIOVASCULAR/HEART		
Heart trouble	☐	☐
Chest pain	☐	☐
Shortness of breath	☐	☐
Swelling of feet, ankles and hands	☐	☐
RESPIRATORY		
Chronic or frequent coughs	☐	☐
Spitting up blood	☐	☐
Shortness of breath	☐	☐
Wheezing	☐	☐
GASTROINTESTINAL		
Loss of appetite	☐	☐
Change in bowel movements	☐	☐
Nausea or vomiting	☐	☐
Frequent diarrhea	☐	☐
Painful bowel movements	☐	☐
Blood in stools	☐	☐
Constipation	☐	☐
Rectal bleeding	☐	☐
Abdominal pain	☐	☐

	Yes	No
GENITOURINARY		
Frequent urination	☐	☐
Burning or painful urination	☐	☐
Blood in urine	☐	☐
Change in force or stream when urinating	☐	☐
Incontinence or dribbling	☐	☐
Kidney stones	☐	☐
Sexual difficulty	☐	☐
Male – testicular pain	☐	☐
Female – pain with periods	☐	☐
irregular periods	☐	☐
vaginal discharge	☐	☐
MUSCULOSKELETAL		
Joint pain	☐	☐
Joint stiffness or swelling	☐	☐
Weakness of muscles/joints	☐	☐
Muscle pain or cramps	☐	☐
Back pain	☐	☐
Cold extremities	☐	☐
Difficulty in walking	☐	☐
SKIN		
Rash or itching	☐	☐
Change in skin color	☐	☐
Change in hair or nails	☐	☐
Varicose veins	☐	☐
NEUROLOGICAL		
Frequent/recurring headaches	☐	☐
Lightheaded or dizzy	☐	☐
Convulsions or seizures	☐	☐
Numbness or tingling	☐	☐
Tremors	☐	☐
Paralysis	☐	☐
Head injury	☐	☐
ENDOCRINE		
Glandular/hormone problem	☐	☐
Excessive thirst or urination	☐	☐
Heat or cold intolerance	☐	☐
Skin becoming drier	☐	☐
Change in hat or glove size	☐	☐
HEMATOLOGIC/LYMPHATIC		
Slow to heal after cuts	☐	☐
Bleeding or bruising	☐	☐
Anemia	☐	☐
Phlebitis	☐	☐
Past transfusion	☐	☐
Enlarged glands	☐	☐

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FAMILY MEDICAL HISTORY:

RELATIONSHIP	Living	Deceased	Age	Diseases
Mother	_____	_____	___	_____
Father	_____	_____	___	_____
_____	_____	_____	___	_____
_____	_____	_____	___	_____
_____	_____	_____	___	_____

Do you or any of your family members have a history of bleeding problems _____ Yes _____ No

Date of last test for colon cancer _____

Relatives with colon cancer _____

Date of last EKG _____ Chest X-Ray _____

FOR WOMEN ONLY

Age of first menstrual period _____ Age of menopause _____ Date of last Pap Smear _____

Age of first pregnancy _____ Number of pregnancies _____ Date of last mammogram _____

Relatives with breast cancer _____

History of hormone use (i.e. estrogen, oral contraceptives) _____

_____

AUTHORIZATION: To the best of my knowledge, the questions on this form have been accurately answered. It is my responsibility to inform the medical office of any changes in my medical status.

_____ _____
Signature of Patient or Guardian Date

_____ _____
Signature of Physician 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)

Revised 5/13
POS® Reorder # 0621422

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