Palatine Heart Center

RAJA SHARMA, MD, FACC, FSCAI
JOEL D. ROBBINS, MD, FACC, FSCAI
JACK V PINTO, MD, FACC, FSCAI
JENNA BUSS, MSN, APN, ANP-BC

PATIENT INFORMATION

Please print and complete all areas – Required for insurance billing

Name: _____
Last First MI

Address: _____
Street City State/Zip

Date of Birth: _____/_____/_____ Gender: M F Marital Status: S M D W

Social Security Number: _____

Primary Phone: _____ Secondary Phone: _____

Work Phone: _____

Email Address: _____

Primary Care Physician: _____ Phone: _____
Please include first & last name

Referring Physician: _____ Phone: _____
Please include first & last name

Pharmacy: _____ City: _____

Emergency Contact: _____ Phone: _____

Please indicate, for normal or stable test results, may we leave a message on your voicemail or answering machine: Yes / No

Signature: _____ Date: _____

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INSURANCE INFORMATION

Please print and complete all areas.
This is necessary to file insurance claims

NAME _____ _____ _____
Last First Mi

PATIENTS EMPLOYER: _____ PHONE ( ) _____ - _____

ADDRESS _____ _____ _____ _____
Street City State Zip

WORK STATUS: Full Part Self-Employed Retired Unemployed Disability

PRIMARY INSURANCE:

Medicare / HMO / PPO
Name of Insured: _____
Relationship to Patient: _____
Employer: _____
DOB: ___/___/___ SSN: ____-____-_____
Insurance Company: _____
Insurance Address: _____
ID #: _____
Group #: _____Policy #_____

SECONDARY INSURANCE:

Medicare / HMO / PPO
Name of Insured: _____
Relationship to Patient: _____
Employer: _____
DOB: ___/___/___ SSN: ____-____-_____
Insurance Company: _____
Insurance Address: _____
ID #: _____
Group #: _____Policy #_____

ASSIGNMENT OF BENEFITS

I authorize payment to Global Care S.C./ Palatine Heart Center for services rendered. While filing the charges is a courtesy that we extend to you, all charges are your responsibility from the date services are rendered. I authorize the release of any information necessary to allow for payment of this claim. A copy of my insurance card has been given for my file.

SIGNATURE _____ DATE: _____/_____/_____

PALATINE HEART CENTER
360 STATION DRIVE, STE. 120
CRYSTAL LAKE, IL 60014
PH: 815-477-8900
FX: 815-477-7160

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PATIENT ACKNOWLEDGEMENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

1.) Protected health information may be disclosed or used for treatment, payment or health care operations; 2.) The Practice has a Notice to Privacy Practices and that the patient has the opportunity to review this Notice; 3.) The Practice reserves the right to change the Notice of Privacy Policies; 4.) The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions; 5.) The patient may revoke this consent in writing at any time and all future disclosures will then cease; 6.) The Practice may condition treatment upon the execution of this consent.

Patient Name (print): _____ Date: _____/_____/_____

Patient Signature: _____ Phone: _____/_____/_____

Authorized Person(s) who can receive/discuss medical information on your behalf:

_____ Phone: _____/_____/_____

Authorized Person(s) relationship to Patient: _____

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Financial Policy

Welcome

Welcome to Global Care, SC dba Palatine Heart Center. We know you have a choice when choosing your medical provider and hope that we meet your expectations. It is our goal to provide you with the best in health care and to make matters of payment as easy as possible.

We accept many insurance plans currently offered in the Chicago area. We will submit your claims on your behalf directly to your insurance carrier. We will send you a statement each month when your account has a balance due.

You are responsible at the time of service for any copayments due based upon your insurance plan. You are also responsible for obtaining any referrals or preauthorization(s) that might be necessary based upon your insurance coverage. Please check with your insurance carrier prior to any testing. Self-pay patients are expected to make payment arrangements at the time of service. Patients with balances that have not been paid after three monthly statements will be turned to a licensed collection agency and may be subject to appointment restrictions and collection service fees.

Patients are required to notify the office at least 24 hours prior to the appointment time to cancel or change a scheduled appointment or be subject to a cancellation fee. Patient's having a chemical stress test (Lexiscan) must notify the office of a cancellation 1 day in advance to avoid a cancellation charge.

Fees:

Cancellation / Reschedule less than 24 hours	$50.00
No Show for appt	$50.00
Cancellation Lexiscan/Myoview Stress Tests less than 24 hours	$250.00
Return Check Fee	$35.00
FMLA/Disability Forms/ Work Release Paperwork/Forms	$50.00
Medical Records	Based upon Illinois State guidelines

_____ _____

(Patient /Guardian Signature) (Date)

_____

(Print Name)

3/2016

Advocate Health Care

Power of Attorney for Health Care Illinois Statutory Short Form

Notice to the Individuals Signing the Power of Attorney for Health Care

No one can predict when a serious illness or accident might occur. When it does, you may need someone else to speak or make health care decisions for you. If you plan now, you can increase the chances that the medical treatment you get will be the treatment you want.

In Illinois, you can choose someone to be your "health care agent". Your agent is the person you trust to make health care decisions for you if you are unable or do not want to make them yourself. These decisions should be based on your personal values and wishes.

It is important to put your choice of agent in writing. The written form is often called an "advance directive". You may use this form or another form, as long as it meets the legal requirements of Illinois. There are many written and on-line resources to guide you and your loved ones in having a conversation about these issues. You may find it helpful to look at these resources while thinking about and discussing your advance directive.

What are the things I want my health care agent to know?

The selection of your agent should be considered carefully, as your agent will have the ultimate decision making authority once this document goes into effect, in most instances after you are no longer able to make your own decisions. While the goal is for your agent to make decisions in keeping with your preferences and in the majority of circumstances that is what happens, please know that the law does allow your agent to make decisions to direct or refuse health care interventions or withdraw treatment. Your agent will need to think about conversations you have had, your personality, and how you handled important health care issues in the past. Therefore, it is important to talk with your agent and your family about such things as:

- What is most important to you in your life?
- How important is it to you to avoid pain and suffering?
- If you had to choose, is it more important to you to live as long as possible, or to avoid prolonged suffering or disability?
- Would you rather be at home or in a hospital for the last days or weeks of your life?
- Do you have religious, spiritual, or cultural beliefs that you want your agent and others to consider?
- Do you wish to make a significant contribution to medical science after your death through organ or whole body donation?
- Do you have an existing advanced directive, such as a living will, that contains your specific wishes about health care that is only delaying your death? If you have another advance directive, make sure to discuss with your agent the directive and the treatment decisions contained within that outline your preferences. Make sure that your agent agrees to honor the wishes expressed in your advance directive.

(continued)

What kind of decisions can my agent make?

If there is ever a period of time when your physician determines that you cannot make your own health care decisions, or if you do not want to make your own decisions, some of the decisions your agent could make are to:

- Talk with physicians and other health care providers about your condition.
- See medical records and approve who else can see them.
- Give permission for medical tests, medicines, surgery, or other treatments.
- Choose where you receive care and which physicians and others provide it.
- Decide to accept, withdraw, or decline treatments designed to keep you alive if you are near death or not likely to recover. You may choose to include guidelines and/or restrictions to your agent's authority.
- Agree or decline to donate your organs or your whole body if you have not already made this decision yourself. This could include donation for transplant, research, and/or education. You should let your agent know whether you are registered as a donor in the First Person Consent registry maintained by the Illinois Secretary of State or whether you have agreed to donate your whole body for medical research and/or education.
- Decide what to do with your remains after you have died, if you have not already made plans.

Talk with your other loved ones to help come to a decision (but your designated agent will have the final say over your other loved ones). Your agent is not automatically responsible for your health care expenses.

Whom should I choose to be my health care agent?

You can pick a family member, but you do not have to. Your agent will have the responsibility to make medical treatment decisions, even if other people close to you might urge a different decision. The selection of your agent should be done carefully, as he or she will have ultimate decision-making authority for your treatment decisions once you are no longer able to voice your preferences. Choose a family member, friend, or other person who:

- Is at least 18 years old;
- Knows you well;
- You trust to do what is best for you and is willing to carry out your wishes, even if he or she may not agree with your wishes;
- Would be comfortable talking with and questioning your physicians and other health care providers;
- Would not be too upset to carry out your wishes if you became very sick; and
- Can be there for you when you need it and is willing to accept this important role.

What if my agent is not available or is unwilling to make decisions for me?

If the person who is your first choice is unable to carry out this role, then the second agent you chose will make the decisions; if your second agent is not available, then the third agent you chose will make the decisions. The second and third agents are called your successor agents and they function as back-up agents to your first choice agent and may act only one at a time and in the order you list them.

(continued)

What will happen if I do not choose a health care agent?

If you become unable to make your own health care decisions and have not named an agent in writing, your physician and other health care providers will ask a family member, friend, or guardian to make decisions for you. In Illinois, a law directs which of these individuals will be consulted. In that law, each of these individuals is called a "surrogate". There are reasons why you may want to name an agent rather than rely on a surrogate:

- The person or people listed by this law may not be who you would want to make decisions for you.
- Some family members or friends might not be able or willing to make decisions as you would want them to.
- Family members and friends may disagree with one another about the best decisions.
- Under some circumstances, a surrogate may not be able to make the same kinds of decisions that an agent can make.

What if there is no one available whom I trust to be my agent?

In this situation, it is especially important to talk to your physician and other health care providers and create written guidance about what you want or do not want, in case you are ever critically ill and cannot express your own wishes. You can complete a living will. You can also write your wishes down and/or discuss them with your physician or other health care provider and ask him or her to write it down in your chart. You might also want to use written or on-line resources to guide you through this process.

What do I do with this form once I complete it?

Follow these instructions after you have completed the form:

- Sign the form in front of a witness. See the form for a list of who can and cannot witness it.
- Ask the witness to sign it, too.
- There is no need to have the form notarized.
- Give a copy to your agent and to each of your successor agents.
- Give another copy to your physician.
- Take a copy with you when you go to the hospital.
- Show it to your family and friends and others who care for you.

What if I change my mind?

You may change your mind at any time. If you do, tell someone who is at least 18 years old that you have changed your mind, and/or destroy your document and any copies. If you wish, fill out a new form and make sure everyone you gave the old form to has a copy of the new one, including, but not limited to, your agents and your physicians.

What if I do not want to use this form?

In the event you do not want to use the Illinois statutory form provided here, any document you complete must be executed by you, designate an agent who is over 18 years of age and not prohibited from serving as your agent, and state the agent's powers, but it need not be witnessed or conform in any other respect to the statutory health care power.

If you have questions about the use of any form, you may want to consult your physician, other health care provider, and/or an attorney.

Advocate Health Care

00-5026 10/14

Power of Attorney for Health Care Illinois Statutory Short Form

This Power of Attorney revokes all previous Powers of Attorney for Health Care

You must sign this form and a witness must also sign it before it is valid

My name (Print your full name): _____

My address: _____

I want the following person to be my health care agent:
(an agent is your personal representative under state and federal law):

Agent name: _____ **Agent phone number** _____

Address: _____

My agent can make health care decisions for me, including:

- Deciding to accept, withdraw or decline treatment for any physical or mental condition of mine, including life-and-death decisions.
- Agreeing to admit me to or discharge me from any hospital, home, or other institution, including a mental health facility.
- Having complete access to my medical and mental health records, and sharing them with others as needed, including after I die.
- Carrying out the plans I have already made, or, if I have not done so, making decisions about my body or remains, including organ, tissue or whole body donation, autopsy, cremation, and burial.

The above grant of power is intended to be as broad as possible so that my agent will have the authority to make any decision I could make to obtain or terminate any type of health care, including withdrawal of nutrition and hydration and other life-sustaining measures.

I authorize my agent to (please check any one box):

☐ Make decisions for me only when I cannot make them for myself. The physician(s) taking care of me will determine when I lack this ability.

(If no box is checked, then the box above shall be implemented.) OR

☐ Make decisions for me starting now and continuing after I am no longer able to make them for myself. While I am still able to make my own decisions, I can still do so if I want to.

Successor health care agents (optional):

If the agent I selected is unable or does not want to make health care decisions for me, then I request the person(s) I name below to be my successor health care agent(s). Only one person at a time can serve as my agent (add another page if you want to add more successor agent names):

Successor agent #1 name: _____ **Phone number:** _____

Address: _____

Successor agent #2 name: _____ **Phone number:** _____

Address: _____

Advocate Health Care®

POWER OF ATTORNEY FOR HEALTHCARE
ILLINOIS STATUTORY SHORT FORM

Patient Label

Power of Attorney for Health Care Illinois Statutory Short Form

The subject of life-sustaining treatment is of particular importance. Life-sustaining treatments may include tube feedings or fluids through a tube, breathing machines, and CPR. In general, in making decisions concerning life-sustaining treatment, your agent is instructed to consider the relief of suffering, the quality as well as the possible extension of your life, and your previously expressed wishes.

Your agent will weigh the burdens versus benefits of proposed treatments in making decisions on your behalf.

Additional statements concerning the withholding or removal of life-sustaining treatment are described below. These can serve as a guide for your agent when making decisions for you. Ask your physician or health care provider if you have any questions about these statements.

Select only one statement below that best expresses your wishes (**OPTIONAL**):

☐ The quality of my life is more important than the length of my life. If I am unconscious and my attending physician believes, in accordance with reasonable medical standards, that I will not wake up or recover my ability to think, communicate with my family and friends, and experience my surroundings, I do not want treatments to prolong my life or delay my death, but I do want treatment or care to make me comfortable and to relieve me of pain.

☐ Staying alive is more important to me, no matter how sick I am, how much I am suffering, the cost of the procedures, or how unlikely my chances for recovery are. I want my life to be prolonged to the greatest extent possible in accordance with reasonable medical standards.

Specific limitations to my agent's decision-making authority:

The above grant of power is intended to be as broad as possible so that your agent will have the authority to make any decision you could make to obtain or terminate any type of health care. If you wish to limit the scope of your agent's powers or prescribe special rules or limit the power to authorize autopsy or dispose of remains, you may do so specifically in this form.

_____

_____

My signature: _____ **Today's date:** _____

Have your witness agree to what is written below, and then complete the signature portion:

I am at least 18 years old. (check one of the options below):

☐ I saw the principal sign this document, or

☐ The principal told me that the signature or mark on the principal signature line is his or hers.

I am not the agent or successor agent(s) named in this document. I am not related to the principal, the agent, or the successor agent(s) by blood, marriage, or adoption. I am not the principal's physician, mental health service provider, or a relative of one of those individuals. I am not an owner or operator (or the relative of an owner or operator) of the health care facility where the principal is a patient or resident.

Witness printed name: _____

Witness address: _____

Witness signature: _____ **Today's date:** _____

00-5026

Advocate Health Care®

POWER OF ATTORNEY FOR HEALTHCARE ILLINOIS STATUTORY SHORT FORM

Patient Label