RAJA SHARMA, MD, FACC, FSCAI
JOEL D. ROBBINS, MD, FACC, FSCAI

ILLINOIS CARDIOVASCULAR SPECIALISTS

JACK V PINTO, MD, FACC, FSCAI
DOUGLAS A. TOMASIAN, MD, FSCAI

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 _____ _____ _____
First Last Mi

PATIENTS EMPLOYER: _____ PHONE ( ) ____-_____

ADDRESS _____ _____ _____ _____
Street City State Zip

WORK STATUS: Full Part Self-Employed Retired Unemployed Disability

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

ASSIGNMENT OF BENEFITS

I authorize payment to Illinois Cardiovascular Specialists for services rendered. While filing 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: _____/_____/_____

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Name of Patient (Print) _____ Street Address _____

Phone Number _____ City _____ State _____ Zip _____

Date of Birth _____ Last Four Digits of SSN (optional) _____

I hereby authorize Illinois Cardiovascular Specialists to release/obtain my records to/from:

*Please fill in the complete name and address of the medical facility or entity you would like your records sent to or obtained from. _____

_____

_____

The Protected Health Information I would like to have released is as follows (check one):

___ Release my entire chart (subject to state regulated per page fees)

___ I would like specific dates of service _____

I am requesting my information to be disclosed for the following reason: _____

I understand this authorization will expire 90 days from the date of signature.
I understand I may revoke this authorization in writing at any time.
I understand I am entitled to a copy of this authorization upon request.
I hereby acknowledge that the information I have given on this form with signature is true and correct.
I hereby acknowledge that I have read and fully understand the above statements as they apply to me.

Signature of Patient _____ Date _____

Signature of POA or other individual who has legal authority. _____ Date _____

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PATIENT SELF-ASSESSMENT

Patient Self-Assessment

Please take this self-assessment to see if you might be a candidate for additional screening for potential varicose veins and / or chronic venous insufficiency.

History

Have you ever had varicose veins?	O Yes	O No

Signs and Symptoms

Do you experience any of the following signs and symptoms in your legs or ankles?

Do you experience leg pain, aching or cramping?	O Yes	O No
Do you experience leg or ankle swelling, especially at the end of the day?	O Yes	O No
Do you feel "heaviness" in your legs?	O Yes	O No
Do you experience restless legs?	O Yes	O No
Do you have skin discoloration or texture changes?	O Yes	O No
Do you have open wounds or sores?	O Yes	O No

Risk Factors

Has anyone in your blood-related family ever had varicose veins or been diagnosed with venous reflux disease or chronic venous insufficiency?	O Yes	O No
Have you had any treatments of procedures for vein problems?	O Yes	O No
Do you stand for long periods of time, such as at work?	O Yes	O No

Self-Assessment Results

If you answered yes to one or more of the above questions, please contact us for a consultation to see if you may be candidate for venous reflux disease.

Name:

_____

Contact number:

_____

_____

350 CONGRESS PARKWAY, SUITE E, CRYSTAL LAKE, ILLINOIS 60014
27750 WEST HIGHWAY 22, SUITE 105 and 130, BARRINGTON, ILLINOIS 60010
PHONE 815-477-8900 FAX 815-477-7160

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Illinois Cardiovascular Specialists Financial Policy

Thank you for choosing Global Care S. C. (dba Illinois Cardiovascular Specialists) as your healthcare provider. We know you have a choice when choosing your medical provider and hope that we meet your expectations. A clear understanding of our patient financial policy is important to our professional relationship. Please understand that payment for services is part of that relationship. Please ask us if you have any questions about our fees, policies, or your responsibilities. It is your responsibility to notify the office of any patient information changes such as address changes, name changes or changes in insurance providers.

Co-Pays

The patient is expected to present an insurance card at each visit. All copayments must be paid at the time of service. There will be no exceptions for this. If a copayment cannot be made our provider cannot see you that day.

Self-pay patients

Self-pay patients will be required to pay $250 for any initial consultation and $175 dollars for any subsequent visits. Any remaining balance will be billed to the patient.

Referrals and pre-authorizations Due to the many changes in insurance policies it is no longer an easy task to interpret each individual policy. **It is your responsibility to know your individual policy.** Certain health insurances such as HMOs require that you obtain referral from your primary care provider before visiting a specialist. If your Insurance company requires a referral, you are responsible for obtaining it. Failure to obtain a referral could result in **the patient** being responsible for **all costs** incurred. We will be unable to see you if you do not properly obtain a referral. Pre-authorization will be obtained by our office for any testing ordered by our physicians. Understand that pre-authorization is not a guarantee of payment. You are ultimately responsible for payment of services rendered if your insurance carrier does not pay for any reason.

Payment balances

In order to provide a high level of service and to continue to run our independent practice we expect full payment at the time of service. We accept many insurance plans currently offered in the Chicago Area. It is our responsibility to accurately and quickly bill your insurance provider(s) on your behalf.

If a patients' balance after insurance remittance is $250 or less, we expect full payment within 30 days of sending you a billing statement. If a patients' balance after insurance remittance is greater than $250 we expect at least a $250 payment within 30 days of your billing statement. Any remaining balance will

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be expected to be paid off in full within 3 months of the first billing statement. If no attempt towards payment has been made after 3 months, they will be turned over to licensed collection agency and will be subject to any applicable placement fees. Accounts with payment plans not paid in full after 3 months will incur a monthly non-adjustable service charge of $20. We will require a valid credit card on file and your card will be charged monthly. Payment plan accounts not paid in full after 6 months will be turned over to a licensed collection agency and will be subject to any applicable placement fees. At this point the patient most likely will be discharged from the practice.

Missed appointments

Illinois Cardiovascular Specialist requires 24-hour notice of appointment cancellation. Appointments missed and not previously canceled maybe charged a fee of $50.00.

Returned checks

The charge for return check is $35 dollars payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check.

This financial policy helps the office provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please contact or ask us.

Fees:

Cancellation/ Reschedule less than 24hrs	$50.00
No show for appt	$50.00
Lexiscan/Myoview Stress test Cancelation less than 24 hrs / use of Caffeine	$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

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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: _____