RAJA SHARMA, MD, FACC, FSCAI
NICOLE MANUEL, APN
MELISSA MACDONALD, APRN, CNP

ILLINOIS CARDIOVASCULAR SPECIALISTS

DOUGLAS A. TOMASIAN, MD, FSCAI
DAVID BROMET, MD, FACC

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 Other Marital Status: S M D W

Last 4 Digits of Social Security Number: _____ Race _____ Language_____

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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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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Illinois Cardiovascular Specialists Financial Policy 2025

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.

After insurance remittance we expect full payment within 30 days of sending you a billing statement. If for some reason you are unable to pay your balance within 30 days you will be required to set up a payment plan and will be expected to pay off balance, in full, within 3 months of the first billing statement. We will require a valid credit card on file and your card will be charged monthly, after the first 2 months balances that have not been paid in full will incur a monthly non-adjustable service charge of $20. Accounts not paid in full after 3 months will be turned over to a licensed collection agency and will be subject to any applicable placement fees. If no attempt toward payment has been made after 2 consecutive months from the first billing statement, they will be turned over to a licensed collection

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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/ no show for appt	$50.00
No show for in office procedures	$100.00
Lexiscan/Myoview Stress test Cancelation less than 24 hrs / use of Caffeine	$75.00
Return check fee	$35.00
FMLA/ Disability forms/work release Paperwork/ Forms	$50.00
Medical Records	Based upon Illinois State Guidelines

_____ _____

(Patient Print) Date

_____ _____

(Patient Signature) Date

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PATIENT WAIVER/CONSENT AND AGREEMENT TO PAY

I, _____understand that by signing this waiver, I am agreeing to pay for any non-covered services provided by Dr. Joel Robbins/ Dr. Jack Pinto/ Dr.Raja Sharma/ Dr. Douglas Tomasian/ Dr. David Bromet

Every billing effort will be made to obtain reimbursement of the services provided from my insurance carrier. In the event of a denial of payment by the insurance carrier, I agree to be responsible for the allowed amount of the charges or a remaining balance after my insurance has paid in full. Also, If I fail to provide the correct/ updated insurance information at the time of service, in order for our office staff to obtain preapproval, I agree to be responsible for the allowed amount of the charges.

I have read and understand the Waiver /Consent to Pay Form and accept all items listed above.

Patient Signature: _____Date: _____

Witness Signature: _____Date: _____

284 MEMORIAL COURT, SUITE B, CRYSTAL LAKE, ILLINOIS 60014
600 HART RD., SUITE 100, BARRINGTON, ILLINOIS 60010
PHONE 815-477-8900 FAX 815-477-7160

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: _____

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:** _____

005026

Advocate Health Care

POWER OF ATTORNEY FOR HEALTHCARE
ILLINOIS STATUTORY SHORT FORM

Patient Label