NORTH SUBURBAN HEALTHCARE

REGISTRATION FORM

(Please Print)

Today's date:	

PATIENT INFORMATION

Patient's last name:	First:	Middle:	(circle one) Single/ Married Widowed/ Divorced

Birth date: / /	Age:	Sex: ❑ M ❑ F	Sexual Orientation (circle one) Heterosexual/ Homosexual Bisexual/ Decline to specify

Ethnicity/ Race(circle one) American Indian / Hispanic or Latino / Asian African American / Native Hawaiian / White / Decline to specify	Preferred Language:

Street Address	City:	State:	ZIP Code:	Home Phone: ( )
Occupation:	Employer:			Employer phone no.: ( )

Email Address:

Who may we thank for referring you?

Is it okay to leave a detailed message on phone: YES OR NO

Preferred phone number:

Preferred Pharmacy and location:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:
		( )	( )

INSURANCE INFORMATION

(Please give your insurance card to the receptionist every time.)

Person responsible for account:	Birth date: / /	Address (if different):	Home phone no.: ( )

Subscriber's name:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

ASSIGNMENT AND RELEASE

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize North Suburban Healthcare or insurance company to release any information required to process my claims.

Responsible Party Signature *Date*

PLEASE LIST OTHER DOCTORS YOU ARE SEEING?

Cardiologist _____

Endocrinologist_____

Gastroenterologist_____

Gynecologist_____

Nephrologists_____

Neurologist _____

Oncologist_____

Ophthalmologist _____

Pain management _____

Psychiatrist _____

Pulmonologist_____

Urologist _____

Other _____

Past Medical and Ongoing medical history (Please List):

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____
9._____
10._____
11._____
12._____
13._____
14._____
15._____

Family History	(Circle one)	Any Medical Conditions?
Mother	Alive/ Deceased	
Father	Alive/ Deceased	
Brothers	Alive/ Deceased	
Sisters	Alive/ Deceased	
Children	Alive/ Deceased	

Past (Please List) Surgeries:

1.
2.
3.
4.
5.

Allergies: (PLEASE LIST)

1.
2.
3.

Medication
(list below)

1.
2.
3.
4.

Health Habits	**(circle one)**
Smoking	YES-----NO-----FORMER
Alcohol	YES-----NO
Illicit drugs	YES-----NO

Last time any were done?(if applicable)	Date(if remembered)
Pap Smear	
Mammogram	
Colonoscopy	
Pneumococcal Vaccine	
Influenza Vaccine	
Tetanus Vaccine	

North Suburban Healthcare
1870 West Winchester Rd, Suite 248
Libertyville, IL 60048
Telephone 847-281-8902 Fax 847-281-8906

AS A PATIENT IT IS YOUR RESPONSIBILITY TO:

1. Provide correct insurance information and proper I.D.
2. Know your insurance benefits.
3. Notify your insurance company prior to any surgical procedure tests.
4. Schedule pre-operative physicals and lab appointments.
5. Schedule follow up appointments for all test results.
6. Provide 3 days notice for prescription refills. Please **DO NOT** wait until the last minute for refill requests.

OFFICE POLICIES

1. The office has a 24 hour answering service in case of urgent problems. After regular business hours you can call the office phone and you will be connected with the answering service. In case of emergency please go to the nearest emergency room**.*** **Please be advised that after hours phone calls to the physician will be billed to your insurance**.

2. All patient balances and co-pays **MUST** be paid in full prior to seeing the doctor. We may ask you to re-schedule your appointment if this is not done.

3. Any paperwork needed to be picked up must be done by the patient or someone authorized to do so, during regular office hours. We do not e-mail, or mail such information.

4. There is a fee of **$25.00 dollars** for all forms filled out by the doctor. Please allow 5 business days to honor the request.

5. There is a basic fee of **$25.00 dollars** for medical record requests. Amount may vary depending on the size of the record. Amounts are based off the Illinois Comptroller's Office Official Website. Please allow 5-7 business days to honor the request.

6. Please give a 24 hour notice to cancel appointments. There will be a fee of **$25.00 dollars** for no shows or cancellations with less than a 24 hour notice. Patients that are **NO SHOWS** more than twice may be asked to find a new doctor.

7. No postdated checks will be accepted. There is a **$35.00 dollar** fee for **ALL** returned checks.

8. We **DO NOT** do medication refills over **weekends or holidays**.

9. We **DO NOT** refill controlled substances through pharmacy's request. Patient needs to call the office to get medication refilled.

9. Our staff is important to us and we ask that you respect them. Any patient found to be disrespectful will be asked to leave the practice.

10. We will send refills to your pharmacy as a courtesy. We are not responsible for medications dispensed by them including automatic refills, duplicate medications, previous medications you have been on etc.

11. **We DO NOT treat over the phone**. **We will not** call in antibiotics or new medications over the phone. Appointment is required for any change in condition.

I Agree with all of the above:

_____ Date:_____

North Suburban Healthcare
1870 West Winchester Rd, Suite 248
Libertyville, IL 60048
Telephone 847-281-8902 Fax 847-281-8906

PATIENT AGREEMENTS AND AUTHORIZATIONS

CONSENT FOR TREATMENT. I hereby consent to the treatment provided by North Suburban Healthcare and it employees or designees. I authorize the mental and physical healthcare services deemed necessary or advisable by my caregivers to address my needs. (_____)initial here

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION.
I authorize use and disclosure of my personal health information for the purpose of diagnosing or providing treatment to me, obtaining payment for my care, or the purpose of conducting the healthcare operations of the practice. I authorize the practice to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that the practice may release objective clinical information related to my diagnosis and treatment, which may be requested by my insurance company or its designate agent. (_____)initial here

ASSIGNMENT OF INSURANCE BENEFITS/PAYMENTS GUARANTEE/COLLECTION FEE
I authorize payment to be made directly to the practice for insurance benefits payable to me. I understand that I am financially responsible to the practice for any covered or non covered services, as defined by my insurer. I understand that if my account balance becomes overdue and the overdue account is referred to a collection agency, I will be responsible for the cost of collection including reasonable attorneys fees. (_____)initial here

PRIVACY POLICY. I acknowledge having received the practices" Notice Of Privacy Policies". My right including the right to see and copy my records, to limit disclosure of my health information, and to request an amendment to my record, is explained in the policy. I understand that I may revoke in writing my consent for release of my healthcare information, except to the extent the Practice has already made disclosure with my prior consent. (_____)initial here

_____ _____ _____
Patient or authorized person's signature Relationship Date

_____ _____
Witness Signature Date

Patient is unable to sign. Verbal consent given. Reason:_____

North Suburban Healthcare
1870 West Winchester Rd, Suite 248
Libertyville, IL 60048
Telephone 847-281-8902 Fax 847-281-8906

Immunization Information Systems Authorization

I authorize my healthcare provider and a public health agency to collect and enter my Immunization records into the Department of Public Health and Human Services Immunization Information System(IIS). The IIS is a confidential computer system that contains immunization records. I understand that information in the registry may be released to a public health agency as well as my healthcare providers to assist in my medical care and treatment. In addition, information may be released to facilities to comply with state immunization requirements. I understand that I can revoke this authorization and have my record removed at any time by contacting my local health department.

Patient Name (PRINTED) _____ Date of Birth _____

Patient/Guardian Signature _____ Date _____

North Suburban Healthcare
1870 West Winchester Rd, Suite 248
Libertyville, IL 60048
Telephone 847-281-8902 Fax 847-281-8906

Pharmacy Benefits Manager Authorization

Formulary Benefits data are maintained for health insurance providers by originations known as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan. We may need access to your data as maintained by the PBM's to know what medications have been prescribed to you in the past, and to know which drugs are covered by your insurance plan. By signing below I give permission for North Suburban Healthcare to access my pharmacy benefits data electronically. This consent will enable North Suburban Healthcare to :Determine the pharmacy benefits and drug co pays for a patient's health plan, check whether a prescribed medication is covered (in formulary) under a patients plan, display therapeutic alternatives with preference rank(if available) within a drug class for non-formulary medications, determine if a patient's health plan allows electronic prescribing to mail order pharmacies and if so, e-prescribing to their pharmacies, downloads a historic list of all medications prescribed for a patient by another provider. In summary, we ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers.

Patient Name (PRINTED) _____ Date of Birth _____

Patient/Guardian Signature _____ Date _____

North Suburban Healthcare
1870 West Winchester Rd, Suite 248
Libertyville, IL 60048
Telephone 847-281-8902 Fax 847-281-8906

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

Please read this form carefully. The Federal Health Insurance Portability and Accountability Act of 1996 (HIPPA), which became effective April 14, 2003, requires that all of the following elements must be completed for an authorization to be valid.

Patient Name _____

Date of Birth _____

Street Address _____

City, State, Zip Code _____

Phone Number _____

I hereby authorize that the protected health information regarding the above named person be forwarded :

From: Person/ Organization _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

To:(recipient) Person/ Organization _____

Address _____

City _____ State _____ Zip _____

Purpose or Need for Information: _____

Disclosure will include (**check all that apply**):

____Face Sheet	____History & Physical	____Laboratory Report
____Operative report	____Discharge Summary	____Progress/ Physician Notes
____x-ray / radiology report	____Pathology report	____Emergency Report
____Nurse Notes	____EKG/EMG/EEG Report	____Consultation Report

Other : _____

Records for the period(dates) from: _____ to: _____

(Continued on reverse)

I understand that I must check one or more of the following types if health information that I do not want released to the above named Recipient. I understand that if I do not check any of the following three items, the health information released to the name recipient may include any of the following:

____Diagnosis, evaluation, and/ or treatment for alcohol and/or drug abuse

____Psychiatric, psychological records or evaluation and/or treatment for mental, physical, and/or emotional illness including narrative summary, tests, social work assessment, medication, psychiatric examination, progress notes, consultations, treatment plans, and/or evaluation

I understand that this Authorization is subject to revocation/ withdrawal by me at any time in writing to the medical record contact person at this size of care except to the extent the action has already been taken to release the information. This authorization shall remain valid unless revoked. I have the right to inspect a copy of the health information to be released, and if I do not sign this authorization, the organization named above will not release my health information. The above named person/ organization will not refuse to treat me based on whether I agree to allow my health information to be used and disclosed to others.

_____ _____

Signature of Patient Date