Advanced Medical Care, Ltd.

Patient Consent Form

Medical Information Consent

I, _____

give full consent to discuss my medical history, labs procedures, or any other medical related information with:

Consent Name:

Phone Number:

Relationship To Above:

Signature:

Date:

Medical Information Consent

I give consent to Advanced Medical Care LTD to leave results of labs, X-rays and other results on my cell phone or home phone answering machine.

Home Phone Number:

Cell Phone Number:

Signature:

Date:

Advanced Medical Care, Ltd.

Patient Information

Name

Prefix:	First Name:	Middle Name:	Last Name:	Suffix:

Mailing Address

Street Address 1:	Street Address 2:

City:	State:	Country:	Zip:

Home Phone Number:

Cell Phone Number:

Email:

Previous Physcian:

Social Security Number:

Employer Name:

Employer Address:

Employer Phone Number:

Language Spoken At Home:

Ethnicity:

Race:

Patient Sex:

Birth Date:

Marital Status:

Married ☐ Single ☐ Other ☐

Education/Employment Status:

Student ☐ Employed ☐ Unemployed ☐
Retired ☐ Other ☐

Referring Physician:

If not referred by a Physician, who referred you:

Family/Friend ☐ Newspaper ☐ Radio ☐ Community Event ☐ Google ☐
Yellow Pages ☐ Internet ☐ Other

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Payment Information

Who is financially responsible for the bill?:

Self ☐	Spouse ☐	Father ☐	Mother ☐	Child ☐	Other ☐

If "other" please list relationship: _____

If the patient is not responsible for the bill, please fill out the bill payers information:

Name:

Prefix:	First Name:	Middle Name:	Last Name:	Suffix:

Mailing Address

Street Address 1:	Street Address 2:

City:	State:	Country:	Zip:

Billing Address

☐ Check here if billing address is the same as mailing address

Street Address 1:	Street Address 2:

City:	State:	Country:	Zip:

Signature of bill payer:	Date:

Advanced Medical Care, Ltd.

Medical History

Patient Name

Prefix:	First Name:	Middle Name:	Last Name:	Suffix:

Date:	Date of Birth:	Gender:

Reason for Visit

Local Pharmacy

Name:
Address:
Phone:
Fax:

Mail-In Pharmacy

Name:
Address:
Phone:
Fax:

Medications, Supplements, and Vitamins

(please list the **name, dosage,** and **frequency** of current medications)

MEDICATION	DOSAGE	FREQUENCY (how often)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

☐ Patient brought in medication list

Medications reviewed by: _____

Please list all known allergies

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Medical History

Patient Name:

Date of Birth:

Medical History (please check all that apply and diagnosis date)

- ☐ High Blood Pressure _____
- ☐ High Cholesterol _____
- ☐ Diabetes _____
- ☐ Stroke _____
- ☐ Anxiety _____
- ☐ Other _____
- ☐ Arthritis _____
- ☐ Kidney Disease _____
- ☐ Asthma _____
- ☐ Osteoporosis _____
- ☐ Depression _____
- ☐ Thyroid Disease (please specify) _____
- ☐ Heart Disease (please specify) _____
- ☐ Cancer (please specify) _____
- ☐ Clotting Disorder (please specify) _____
- ☐ Acid Reflux _____

Surgical History (please list any surgical procedures, hospitalizations and their dates)

FACILITY	REASON	DATE
1.		
2.		
3.		
4.		
5.		
6.		

Social History

Do you currently smoke/chew tobacco?
Yes ☐ No ☐

If yes, how long have you smoked?

If yes, how much do you smoke per day?

If previously smoked, how long did you smoke?

How much per day?

When did you quit?

Do you currently drink alcohol?
Yes ☐ No ☐

How much do you drink per week?

Do you feel you need to cut back?
Yes ☐ No ☐

Do you exercise regularly?
Yes ☐ No ☐

If yes, how often and how long do you exercise?

Have you used street drugs?
Yes ☐ No ☐

If yes, what have you used?

Do you desire STD screening?
Yes ☐ No ☐

Do you consume caffeine?
Yes ☐ No ☐

Advanced Medical Care, Ltd.

Family History

(Please list below blood relatives that have a history of the following)

Check boxes that apply	Living	Deceased	Age/ Age at Death	Stroke	Hypertension	Kidney Disease	Heart Disease	Diabetes	Cancer	Other
Mother										
Father										
Siblings										
Grand-mothers										
Grand-fathers										
Children										

Please list all other health conditions in your family history

Have you ever had a blood tranfusion?

Yes ☐ No ☐

Date:

Advanced Medical Care, Ltd.

Patient Authorization Release Form

Billing Policy and Patient Responsibility

I hereby acknowledge that I am receiving/about to receive health care. I understand that payment for services rendered on my behalf is my sole responsibility.

I hereby authorize Advanced Medical Care, Inc. and its designated agents to:

Bill my insurer and receive payment directly for all services rendered on my behalf.
Bill me for any amounts not paid by my insurer, including co-payments, deductibles, and non-covered services. I understand such co-payments, deductibles, and non-covered services are determined by my insurer and my insurance policy, and agree to be responsible for all existing balances.
Bill me directly for any services denied by my insurance for pre-existing conditions.
Bill me directly for any services not paid within sixty (60) days from the date of service for:
a) Workman's Compensation
b) Personal Injury claim
c) Auto accident
d) Legal action, whether contemplated, pending, or adjudicated.

I agree that should this account become 60 past due I will pay all financial and collection charges including reasonable attorney charges.

Accepting Assignment

I understand that Advanced Medical Care, Inc. will accept Assignment for all services provided.

Assignment is defined as the "reasonable and customary charge" for covered services. Reasonable and customary charges are established by the insurer (your insurance carrier) for the geographical area in which the service is provided. Advanced Medical Care, Inc. will accept the "assigned" value for all covered services.

Authorization to Release Medical Information

I hereby authorize Advanced Medical Care to release all records pertaining to my medical history, services rendered, or treatment given for the purposes of review, investigation, or evaluation of an application, or the processing of any claim, utilization review, financial audit, or for any other purpose reasonably related to the above enumerated activities.

Liability Release

I authorized access to all my insurance information and medical records necessary to billing the related health care services provided by Advanced Medical Care, Inc. I release Advanced Medical Care, Inc. and its agents from any and all liability claims or damages that may arise from disclosure of such information in the pursuit of payment.

I certify that I have read and have access to a copy of the patient release form. I certify that I understand the contents and my responsibilities.

Print Patient's Name:	Signature of Patient/Representative:	Date:

Witness:	Date:

Advanced Medical Care, Ltd.

Office Policy for Managed Care Insurers

In order to accommodate the needs and requests of our patients, we have enrolled in numerous managed care insurance programs.

While we are pleased to be able to provide this service to you, it is extremely difficult for us to keep track of all the individual requirements of the plans. Each one has different stipulations regarding what services may be performed and how often.

Even within the same insurance company, the plans differ depending upon what type of contract your employer has negotiated.

Providing quality medical care for our patients is our primary concern. We are more than willing to provide that care within your insurance contract guidelines if you let us know at EACH time of services exactly what those guidelines are.

Unfortunately, if you do not inform us of any special requirements in your contract and we subsequently order services, such as lab work, injections, minor procedures, or hospitalizations, that are not covered, we or the selected medical facility will have no choice but to bill YOU directly for those charges. Payment for those charges is then your responsibility.

With your cooperation and help, you should be able to receive all of the benefits offered to you, and we will be able to concentrate on caring for your medical needs.

I have read and understand the office policy stated above and agree to accept responsibility as described.

Signature:

Date:

Advanced Medical Care, Ltd.

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

• Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

• Obtain payment from third-party payers.

• Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions but if you do agree then you are bound to abide by such restrictions.

Patient Name

Prefix:	First Name:	Middle Name:	Last Name:	Suffix:

Relationship to Patient:

Signature:

Date:

For Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

Advanced Medical Care, Ltd.

Office and Financial Policies

We would like to thank you for choosing Advanced Medical Care as your medical provider. As one of our patients, we would like to keep you informed of our current office and financial policies. We require that you read and sign this document prior to any treatment. Please keep this document for future reference.

No Insurance: Payment will be due at the time of service.

Insurance: Please bring your insurance card with you at the time of your appointment. All Insurance companies with which we are contracted as in-network providers require that all co-pays be paid prior to any services being rendered. the co-pay required can not be waived by our practices, as it is a requirement placed on you by your insurance carrier.

You are responsible for any co-insurance, deductibles, or non-covered services not paid by your insurance within the state's required time limitation for paying healthcare claims. you will receive a statement from our office indicating what your insurance has paid. Any balance remaining is due upon receipt.

POS: In order for our office to see you as a patient we will have to be listed with your insurance as your PCP. Your insurance carried required that you obtain a referral from your Primary Care Physical (PCP) before receiving services from a specialist. it is your responsibility to know your insurance requirements. Any services received without a referral or proper authorization will be your responsibility.

Auto Accident Injury: If your injury is due to an automobile accident, we request that you provide us with a copy of the police report, copy of your auto insurance, medical insurance, names, and information of the other parties involved, at the time of your appointment. You will be responsible for the payment of this visit. it is your responsibility to send information resulting from this visit to your insurance company so that you can get reimbursed by them.

Worker's Compensation: If your injury is due to an accident in your workplace, please be sure to contact your employer and inform them of your injury. We will need to receive the required information from your employer before we can process any of your medical claims. Please have your employer contact our Billing person. Failure to properly report this injury to your employer may result in your claims being denied. Denied claims may become your responsibility.

Updating Records: You are responsible for keeping your information current in our office. This includes any address, telephone, work, or insurance changes. We will continue to bill your insurance company for you as long as the information we receive is accurate and complete. In the event, we receive the wrong information from you, any unpaid services provided will be your responsibility and you will have to process your own insurance claim.

Results of lab work and/or diagnostic testing must be given to a patient either by a follow-up visit, email, or phone call.

Phone call from our nurse for lab results during morning nurse visit: $25.00/call
(This fee will NOT be charged if labs are drawn during an office visit when a patient sees the doctor. This fee covers the time allotted for the above phone calls include: physician receiving the results, interpreting the results, comparing these results with past results, making a diagnostic decision and treatment plan, conveying this to the nurse, and the nurse calling the patient to explain the results).

Phone call from nurse for diagnostic testing results: $25.00/call
(This fee will only be charged if patient does not want to come in for a follow-up appointment with the doctor).

Please know that we offer reviews of most lab and test results via phone as a convenience to you. If you wish to avoid paying the above-related fees, you are always welcome to make a follow-up appointment with Dr. Bianchi or Dr. Caccopola to review them in person. Please notes that you will be responsible for your co-pay for these appointments.

X-Rays: All x-rays are the property of Advanced Medical Care LTD. You may sign out the original x-rays so that you make take them to a specialist for consultation. If the x-rays are not returned to our office within 14 days, a $75.00 charge will be added to your statement. We will also provide you with a copy of the radiologist's report when available.

Return Checks: A $30.00 charge will be added to your account for any check returned by your bank for any reason.

Medical Records: As a courtesy, we will send copies of medical records to another physician's office. Copies provided to the Patient for their own records will be subject to the current Illinois Record Copying Fees, as per Illinois law. You will need to sign a letter of release prior to any copies being made, as well as pay for the service in advance. Please allow 7-10 business days for us to copy your records.

Thank you for allowing us to service you.

Patient Signature: Date:

Advanced Medical Care, Ltd.

Notice of Privacy Practices Regarding Your Medical Information

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our Responsibility

We are required by applicable federal and state law to maintain the privacy of your protected health information. "Protected Health Information" (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present, and future physical or mental health or condition and related health care services. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your PHI. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy policy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the terms of our notice effective for all PHI that we maintain, including PHI created or received before we made the changes. Before we make significant change in our privacy practices, we will change this notice and make the new notice available upon request.

For more information about our privacy practices, or for additional copies of this notice, please contact us using the information at the end of this notice.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclose by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

• Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this would include a physical examination.
• Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
• Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting written request to the Privacy Officer:

• The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction. We must abide by it unless you agree in writing to remove it.
• The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
• The right to inspect and copy your protected health information.
• The right to amend your protected health information.
• The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Advanced Medical Care, Ltd.

Notice of Privacy Practices Regarding Your Medical Information

Please contact us for more information.

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services

Office of Civil Rights

200 Independence Avenue, S. W.

Washington, D.C. 20201

(202) 619-0257

Toll Free: 1-877-696-6775

Website: www.hhs.gov

Privacy Officer Contact Information:

Advanced Medical Care

Jen Premas, Privacy Officer

290 N. Rand Road, Suite A

Lake Zurich, IL 60047

Phone: (847) 438-4028

Fax: (847). 438-2462

Email: advmedcare@comcast.net