Preferred Surgicenter, LLC

Patient Demographic Form

(Affix Patient Label Here)

PATIENT INFORMATION				
Last Name:	First Name: Middle Int:		Date of Birth:	Social Security #:
Address:	City:	State:	Zip Code:	Surgeon:
Home Phone #:	Cell Phone #		Work Phone #:	
Maiden Name:	Sex (circle): Male Female		County you live in:	
Ethnicity : (Circle) Hispanic Non Hispanic or Latino	Race: (Circle) White Black Asian American Indian Alaska Native Native Hawaiian Other: _____		Primary Language Spoken? Spouses Name:	
Marital Status (Circle) Single Married Divorced Widow	Patient's Occupation:		Employer's Name:	
Employer's Address: City: State: Zip Code:	Employer's Phone # ( )		Occupation: Working hours:	

PRIMARY INSURANCE INFORMATION			
INSURED:	INSURED DOB:	INSURED SS#	RELATIONSHIP:
EMPLOYER:			EMP. TEL #:
INSURANCE COMPANY:			INSURANCE TEL #:
INSURANCE ADDRESS:			GROUP / ID #:

SECONDARY INSURANCE INFORMATION			
INSURED:	INSURED DOB:	INSURED SS#	RELATIONSHIP:
EMPLOYER:			EMP. TEL #:
INSURANCE COMPANY:			INSURANCE TEL #:
INSURANCE ADDRESS:			GROUP / ID #:

FOR WORKERS COMP / PI / AUTO CASES PLEASE PROVIDE ATTORNEY INFORMATION			
NAME/LAWFIRM:			DATE OF INJURY:
ADDRESS:	CITY:	STATE:	ZIP CODE:
TEL:	FAX:		

EMERGENCY CONTACT INFORMATION			
NAME:	RELATIONSHIP:		LANGUAGE:
ADDRESS:	CITY:	STATE:	ZIP CODE:
HOME TEL#:	CELL TEL#:		WORK TEL#:

Please check the following:

[ ] Yes, I have an Advance Directive / Living Will **[ ] No, I do not have an Advance Directive / Living**

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Affix Patient Label Here

Initial Patient History

Please indicate whether or not you have experienced any of the following.

PAST & PRESENT MEDICAL SURGICAL HISTORY

	No	Yes	Comments
Asthma	☐	☐	
Tuberculosis	☐	☐	
Heart Disease	☐	☐	
Rheumatic Fever	☐	☐	
Chest Pains	☐	☐	
Shortness of Breath	☐	☐	
Cigarette Smoling	☐	☐	
Thrombophlebitis	☐	☐	
Bleeding Problems	☐	☐	
Stroke	☐	☐	
High Blood Pressure	☐	☐	
Varicose Veins	☐	☐	
Anemia	☐	☐	
Hemmorrhoids	☐	☐	
Fissure	☐	☐	
High Cholesterol	☐	☐	
Skin Problems	☐	☐	
Cancer	☐	☐	
Venereal Disease	☐	☐	
Herpes	☐	☐	
Pelvic or Menstrual Pain	☐	☐	

	No	Yes	Comments
Genital Warts	☐	☐	
Thyroid Problem	☐	☐	
Cyst/Skin Growth	☐	☐	
Kidney Disease	☐	☐	
Bladder Infection	☐	☐	
Liver Disease/ Hepatitis	☐	☐	
Diabetes	☐	☐	
Mononucleosis	☐	☐	
Swelling	☐	☐	
German Measles (Rubella)	☐	☐	
Depression	☐	☐	
Headaches	☐	☐	
Blurred Vision	☐	☐	
Epilepsy (seizures)	☐	☐	
Stomach/bowel problems	☐	☐	
Surgery	☐	☐	
Sickle Cell Anemia	☐	☐	
Other Major Illness	☐	☐	
Medicines, Drugs used	☐	☐	
Foot Problems	☐	☐	

Other_____

ARE YOU ALLERGIC TO:

Penicillin	☐	☐
Tetracycline	☐	☐
Aspirin	☐	☐
Codeine	☐	☐
Sulfa	☐	☐

Iodine	☐	☐
Any Kind of Food	☐	☐
Any Metals (jewelry)	☐	☐
Latex	☐	☐

Other Allergies_____

FAMILY HISTORY

Are you adopted? ☐ ☐

Have your grandparents, parents, brothers or sisters ever had:

Cancer	☐	☐
Diabetes	☐	☐
Heart Attack	☐	☐
High Blood Pressure	☐	☐

Sickle Cell Disease	☐	☐
Stroke/ Blood Clots	☐	☐
High Cholesterol	☐	☐

Others_____

FEMALE ISSUES

Breast Pain	☐	☐
Breast Discharge	☐	☐
Breast Lumps	☐	☐

Breast Discomfort	☐	☐
Breast Bleeding	☐	☐

Date of your last menstrual cycle.

List medications you are taking including over the counter medications, diet pills, vitamins and herbal preparations. _____

_____

Nearest Relative:

Name:_____ Address:_____

Phone #: _____ Today's Date:_____

Patient Signature:_____ Witness:_____

Preferred Surgicenter, LLC

PATIENT'S BILL OF RIGHTS

Reasonable, informed participation in decisions involving your health care is your right. The rights of our patients are an important component of our care for you. We respect your rights and request that you recognize your responsibilities too.

Patient's Rights and Responsibilities

1. You have the right to considerate and respectful care.
2. You have the right to every consideration of your privacy concerning your own medical care program. Case discussion, consultation, exam, and treatment are confidential and should be conducted discreetly. Those not involved in your care must have your permission to be present.
3. You have the right to obtain from your physician completed current information concerning your diagnosis, treatment and prognosis in terms that you can understand. When it is not medially advisable to give such information to you, the information should be made available to an appropriate person in your behalf. You have the right to know, by name, the physician responsible for coordinating your care.
4. You have the right to receive from your physician information necessary to give informed consent prior to the start of any procedure and/or treatment. Except in emergencies, such information for informed consent should include, but not necessarily be limited to the specific procedure and/or treatment, the medically significant risks involved, and the probable duration of incapacitation. Where medically significant alternatives for care or treatment exist, or when you request information concerning medical alternatives, you have the right to such information. You also have the right to know the name of the person responsible for the procedures and/or treatment.
5. You have the right to expect that all communications and records pertaining to your care be treated as confidential unless required by law.
6. You have the right to expect that within its capacity the surgery center must make a reasonable response to the request of the patient for services. The center must provide evaluation, service, and/or referral as indicated by the urgency of the case. When medically permissible, you may be transferred to another facility only after you have received complete information and explanation concerning the needs for and alternatives to such a transfer.
7. You have the right to obtain information as to any relationship of the surgery center to other health care and educational institutions insofar as your care is concerned. You have the right to obtain any information as to the existence of any professional relationships or financial interests among individuals, by name who are treating you.
8. You have the right to be advised if the surgery center proposes to engage in or perform human experimentation affecting your care or treatment. You have the right to refuse to participate in such research projects.
9. You have the right to expect reasonable continuity of care. You have the right to know in advance what appointment times and physicians are available and where. You have the right to expect that the surgery center will provide a mechanism whereby you are informed by your physician, or delegate of your physician, of your continuing health care requirements following discharge.
10. You have the right to examine and receive explanation of your bill regardless of the source of payment.
11. You have the right to know what surgery center rules and regulations apply to your conduct as a patient.
12. You or your responsible other has the right to be informed of the complaint process at the surgery center. You should report any concerns about your care or safety issues you encountered during your stay. You may contact the nurse manager for information regarding initiation, review, and resolution of your complaints. You may report issues to the Illinois Department of Public Health at 1-800-252-4343, to Joint Commission at 800-994-6610 www.jointcommision.org, or if Medicare related, www.cms.hhs.gove/center/ombudsman.asp or 800-633-4227.
13. You have the right to an advance directive, such as a living will or healthcare proxy. A patient who has an advance directive should provide a copy to the facility and his/her physician. It is the policy of this facility NOT to honor an advance directive. Information is available regarding Advance Directives at www.idph.state.il.us/public/books/advin.htm.
14. Your right on reporting of pain will be believed and information will be given about pain and pain relief measures. We are a concerned staff committed to pain prevention and management; health professionals who respond quickly to reports of pain management.

PATIENT IS RESPONSIBLE FOR:

1. Being considerate of other patients and personnel and for assisting in the control of noise, smoking, and other distractions.
2. Respecting the property of others and the facility.
3. You have the responsibility of honoring your financial commitments to the surgery center.
4. You are responsible for observing rules and regulations of the surgery center as they apply to your care.
5. Reporting whether he or she clearly understands the planned course of treatment and what is expected of him or her.
6. Keeping appointments and, when unable to do so for any reason, for notifying the facility and physician.
7. Providing caregivers with the most accurate and complete information regarding present complaints, past illnesses, hospitalizations, medications, unexpected changes in the patient's condition or any other patient health matters.
8. Observing prescribed rules of the facility during his or her stay and treatment and, if instructions are not followed, forfeiting the right to care at the facility and being responsible for the outcome.
9. Promptly fulfilling his or her financial obligations to the facility.
10. Asking your doctor what to expect regarding pain and pain management.
11. Discussing pain relief options with your doctor.
12. Working with your doctor to develop a pain management plan.
13. Helping your doctor assess pain and tell him if your pain is not relieved.
14. Telling your doctor about any worries you have about taking pain medications.

I have read my rights and responsibilities as a patient at this surgery center and agree to all the above.

Patient_____ **Date**_____
Signature

Witness_____ **Date**_____
Signature

Preferred Surgicenter, LLC

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to the successful treatment of your condition. Please understand that payment of your bill is considered part of your treatment. Your clear understanding of our Financial Policy is important to our professional relationship. Please call our billing department if you have any questions. They may be reached at **708 942 6030**

- FULL PAYMENT IS DUE AT THE TIME OF SERVICE
- WE ACCEPT CASH, CREDIT CARDS (VISA, MASTERCARD, AMERICAN EXPRESS)
- ALL PATIENTS MUST COMPLETE OUR "PATINET REGISTARTION FORM" AND OTHER RALATED FORMS
- FOR CASES WHICH WE BILL INSURANCE DIRECTLY, WE MUST HAVE A COPY OF THE INSURANCE ID CARD.
- **IF PAYMENT IS NOT RECEIVED FROM THE INSURANCE CARRIER OR OTHER RESPONSIBLE THIRD PARTY IN 90 DAYS, WE HAVE THE RIGHT TO BILL YOU DIRECTLY.**
- PLEASE NOTIFY US IMMEDIATELY OF ANY CHANGES IN YOUR INSURANCE OR COVERAGE.
- 24 HOURS NOTICE IS REQUIRED FOR COPIES OF MEDICAL RECORDS OR X-RAYS AND THERE MAY BE A NOMINAL FEE.

UCR (USUAL AND CUSTOMERY RATES)

We are committed to provide the best treatment possible for our patients and we charge what is usual and customary for our area. You are responsible for payment in full regardless of any insurance company's arbitrary determination of UCR rates.

SELF PAY

We expect payment at time of service unless prior arrangement has been made.

WORKERS COMPENSATION

If you are here as a result of work related injury, we will require information regarding both health insurance and your employer's Worker's Compensation insurance. We will also need to verify that your employer assume responsibility for charges incurred. If we cannot verify responsibility or we are unable to obtain information on your employer's Workers Compensation insurance as a courtesy we will bill your health insurance carrier. If payment is not received from these third parties within 90 days, we have the right to bill you directly.

ACCIDENT CLAIMS

If you are here as a result of an accident claim, we will require information regarding both health insurance and accident insurance. In addition, we will need the name, address and phone number of your attorney. In the case of a lawsuit we may need to file liens for payment. If payment is not received from these third parties within 90 days, we have the right to bill you directly.

I understand that if the office agrees to bill insurance as a courtesy, I must submit information as needed to ensure payment for services rendered to me. I understand that I am ultimately responsible for payment for all services.

Name of Patient _____ Signature of Patient or Responsible Party _____ Date _____

Preferred Surgicenter, LLC

10 Orland Square Dr.
Orland Park, IL 60462
(708) 942-6030

ASSINGMENT OF BENEFITS

I hereby authorize payment directly to the provider of service. I understand that I am financially responsible to the provider of service.

FINANCIAL AGREEMENT

The undersigned agrees, as the patient or their guarantor, that in consideration of the service provided to the patient to obligate himself/herself to pay the provider of services account in accordance with their regular terms. Should the account be referred to attorney for collection or any collection agency, the undersigned shall pay reasonable attorney's fees and collection expenses. All delinquent accounts bear interest at the legal rate.

RELEASE OF INFORMATION

A. GENERAL RELEASE:

I hereby authorize ***Preferred Surgicenter LLC.*** and any physician or other health care provider who may treat me to release ANY AND ALL INFORMATION IN MY MEDICAL RECORDS to:

a) Entities involved in billing and collection for ***Fullerton Surgery Center*** and third party payors
responsible for payments of patient charges and or
b) any organization or government agency authorized to review quality, utilization and/or cost of care.

ASSERT THAT I HAVE READ AND UNDERSTAND THIS FORM, THAT I FREELY AND VOLUNTARILY ACCEPT ITS TERMS, AND THAT I AM THE PATIENT OR AM AUTHORIZED TO SIGN ON THE PATIENTS BEHALF. (If the patient's representative is signing for the patient, all references on this form "I" or "My" shall refer to the "the patient" as applicable).

Patient Name (please print	Date
Patient signature	Date
Patient's Representative	Relationship to patient

Preferred Surgicenter, LLC

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS.

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/pr employee health care benefits coverage with the attached captioned, and hereby assign and convey directly to ***Preferred Surgicenter, LLC.*** all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from: such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payment's, I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request form such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at doctor and clinics expenses. I understand all delinquent accounts bear interest at the legal rate. Should this assignment be prohibited in part or in whole under any anti-assignment provision of my policy/plan, please advise and disclose to my provider in writing such anti-assignment provision within 30 days upon receipt of my assignment, otherwise this assignment should be reasonably expected to be effective and such anti-assignment is waived. This assignment will remain in affect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ _____

Signature of Insured/Guardian Date

Preferred Surgicenter, LLC

Notice of Privacy Practices Form

I have received a copy of the Notice of Privacy Practices:

X Paper

☐ Electronic Mail

Please note: we shred patient records after seven (7) years. If you would like to take your records afterwards you may request it in writing.

Name of Patient: _____

Signature of Individual Acknowledging NPP _____

Patient
Healthcare Surrogate
Personal Representative

Employee Witness: _____

Date: _____

Preferred Surgicenter, LLC was unable to attain patient acknowledgment of the Notice of Privacy Practices. Please explain below circumstances of patients' refusal to acknowledge the Notice of Privacy practices in the section provided below.

Name of Employee: _____

Employee Signature: _____

Date: _____

A copy of this form should be placed in the patient's medical record.