Surgeons of
Lake County, LLC

Dear ,

Welcome to Surgeons of Lake County, L.L.C.. We appreciate the trust and confidence you have placed in our practice. In return, we are committed to providing you with the best health care possible.

Our Office Hours
We are open Monday through Friday from 9:00 a.m. to 5:00 p.m.

Visiting Our Office
To schedule an appointment, call our office at (847) 816-7495.

We recognize that your time is valuable, and we make every effort to see you at the appointed time. We appreciate your patience if there is a delay due to unexpected circumstances. If you are going to be late for your appointment, please telephone before you come, because we might need to reschedule your appointment. If you must cancel or reschedule your appointment, please call at least 24 hours in advance, as this will allow another patient to use this time.

To expedite your registration, we have enclosed our new patient forms for you. Please bring the completed forms with you, along with your ID, insurance card(s) and a list of current medications to your appointment on at . If you have any special needs or requirements for your appointment, please let our staff know and we will try to accommodate your requests.

In Case of Emergency
If you have a life-threatening emergency at any time, you should call 911.

If you have any other emergency after regular business hours, call the office telephone number and the answering service will be able to contact the doctor.

Thank you for choosing Surgeons of Lake County, L.L.C. for your care. Please feel free to call us anytime with your questions or concerns.

We look forward to meeting you.

Sincerely,
The team at Surgeons of Lake County, L.L.C.

Surgeons of
Lake County, LLC

PATIENT INFORMATION

Name:
Address:

Email:

SSN:
Date of Birth: **Age:**
Sex: **Race:**
Ethnicity:
Marital Status:
Occupation:

Home:
Work:
Mobile:

Employer:
Address:,

Employer Phone:

PRIMARY INSURANCE INFORMATION

Name:
Address:

SSN:
Date of Birth:
Sex:

Name of Primary Ins:
Group

Home:
Work:
Mobile:

Employer:
Address:

Employer Phone:

Member ID#:

SECONDARY INSURANCE INFORMATION

Name:
Address:

SSN:
Date of Birth:
Sex:

Name of Secondary Ins:
Group #:

Home:
Work:
Mobile:

Employer:
Address:

Employer Phone:

Member ID#:

ASSIGNMENTS OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or my dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I hereby authorize my insurance company to pay and hereby assign directly to the Surgeons of Lake County, LLC, all benefits, if any, otherwise payable to me for his/her services. I understand I am financially responsible for all charges incurred on behalf of myself or my dependent(s). I further acknowledge that any insurance benefits, when received by and paid to the Surgeons of Lake County, LLC, will be credited to my account, in accordance with the above said assignment.

_____ _____

Authorized Signature Date

_____

Printed Name

Surgeons of
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Welcome to the Surgeons of Lake County. We strive to assist our patients in choosing an appropriate plan of treatment by providing them with the knowledge they need to make an informed decision in regards to their surgical needs and personal situation. The following information is intended to acquaint you with some of our policies in order to assist you during your care with our office. We do reserve the right to alter these policies as we feel appropriate.

- Our office is open Monday-Friday from 9:00 am to 5:00 pm. We are closed daily for lunch between 12:00 pm and 1:00 pm. Patients are seen by appointment only. Please call our office to schedule an appointment. If you need to cancel your appointment, please call our office 24 hours prior to your appointment.

- We make every effort to be on time, however, emergencies and other unforeseen events do arise that can cause our physicians to be late or to have to cancel their office appointments. We respect your time and understand you may have had to adjust your schedule to make your appointment. We do apologize in advance for any inconvenience this may cause and will notify you as soon as possible. Please be sure your telephone numbers are kept current with our office.

- It is important that you notify our staff of any demographic, insurance or health history changes. Be sure to bring a legal identification card, your insurance card(s), a list of current medication including frequency and dosage and a list of any recent lab tests, radiology or procedures recently performed and the name of the facility and doctor that ordered it to every visit.

- Co-pays are collected at time of service. Anyone refusing to pay their co-pay will be reported to their insurance company for breach of contract. Any future visits will require payment in full at time of service. Uninsured patients are expected to pay in full at time of service unless previous arrangements have been made.

- We accept cash, check, money orders, Visa, Mastercard, Discover, American Express and Care Credit. No post-dated checks will be accepted. There is a $35 fee for any returned check.

- For all statement, billing or payment plan questions, please speak with our billing department.

- During non-office hours should you have a medical emergency, please call 911 or go to your nearest emergency room. If you have an urgent issue and need to speak with our physician on call, our answering service will assist you by paging a physician. Please understand the physician may be in surgery and may not be able to return your call immediately.

- Refill requests are handled during normal office hours. Prescriptions will not be refilled during non-office hours. Please have your pharmacy fax a refill request form to our office.

- We comply with all HIPAA regulations with regards to medical records. Medical records are released with written consent by the patient or legal guardian within 30 days. Medical records will be released free of charge to other treating physicians as a professional courtesy. Any other requests for medical records are subject to reproduction and shipping fees in accordance with state and federal laws.

- There is a $15 charge for each disability and FMLA form. This fee must be paid prior to these forms being completed. Due to the excessive requests by employers and insurance companies, it is our policy to require 14 business days for the completion of these forms. Duplicate requests will not expedite the handling of these forms. Please notify your insurance company/employer of our policy.

- Our staff is important to us and we ask that our patients and guests respect our staff. Any patient or guest found abusing our staff will be asked to leave the premises and/or find another physician.

- In addition, we ask that you respect one another. Please refrain from wearing strong perfumes, lotions, colognes or any other item that can cause our patients, staff, or physicians to suffer from allergic reactions or respiratory distress. We reserve the right to ask anyone to leave immediately for the safety of those around them.

We hope that we are able to meet your needs and please let us know if there is anything we can do to help you. We understand that surgery can be a scary time for you, we promise to be honest and forthcoming and hope you will be too. Thank you for choosing our practice for your surgical needs.

Surgeons of
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HOW WE WILL USE AND DISCLOSE PROTECTED HEALTH CARE INFORMATION AND YOUR CONSENT TO DO SO.

You entrust us with your personal health and limited financial information. We take that trust very seriously. We receive personal, nonpublic information about you through patient information forms, credit cards, checks or other communication in writing, electronically and over the phone. We may also receive information from your transactions with others such as your insurance company or another health care entity.

In summary, we **do not** share any nonpublic personal information about you with any third parties, except as necessary to give you care or bill for that care except as required by law. Our outside service providers with whom we share information are legally bound not to disclose or reuse your information in any way. We restrict access to your personal information to those of our employees who need to know this information to provide you care. In addition, you can feel comfortable knowing we maintain physical, electronic and procedural safeguards that protect you personal information.

We have available for you to read now and/or take home a detailed booklet of the **NOTICE OF PRIVACY PRACTICES** as required by Health Insurance and Accountability Act, **HIPAA**. Please sign that you have had the opportunity to read it now or have taken one home to read. You are consenting to our use and disclosure based on the booklet as summarized above.

If you have any questions, please contact us. You may avoid this consent by written notice at any time.

PATIENT SIGNATURE_____ **DATE**_____

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Patient Records of Disclosures

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means.

I wish to be contacted in the following manner (check all that applies):

__ **Home Telephone and/or Cell Phone**

__ OK to leave message with detailed information

__ Leave message with call back number only

__ **Written Communication**

__ OK to mail to my home address

__ OK to mail to my work/office address

__ OK to fax to this number: _____

__ **Work Telephone**

__ OK to leave message with detailed information

__ Leave message with call back number only

__ **Email:** _____

__ **Other :**

Explain:_____

_____

Please send all prescriptions to the following pharmacy unless otherwise indicated by me or my representative:

*Pharmacy Name:_____ Address: _____

Phone: _____ Fax: _____

Please list below all non-physician individuals to whom we may disclose your health information:

Name _____ Relationship _____Phone_____

Email _____ Access to your portal account: Yes No

Name _____ Relationship _____ Phone_____

Email _____ Access to your portal account: Yes No

Name _____ Relationship _____Phone_____

Email _____ Access to your portal account: Yes No

Please list all your healthcare providers:

Name _____ Specialty__ _____Phone_____

Name _____ Specialty__ _____Phone_____

Name _____ Specialty__ _____Phone_____

Name _____ Specialty__ _____Phone_____

Name _____ Specialty__ _____Phone_____

The Privacy Rule generally requires healthcare providers to take responsible steps to limit the use or disclosure of, and request for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

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Note: Uses and disclosures for TPO may be permitted without prior consent in any emergency.

HEALTH HISTORY

Patient #:
Patient Name **Date of Birth:**

Welcome to our practice. As a new patient, please fill out the information found below to the best of your ability.

Chief Complaint: _____

History of Present Illness:

Location: _____
(Where is the pain/problem?)

Quality _____
(Example: normal versus abnormal color, activity, etc)

Severity _____
(How severe is the pain/problem on a scale of 1-5 with 5 being the most severe?)

Duration _____
(How long have you had this pain/problem? Or When did it start?)

Timing _____
(Does the pain/problem occur at a specific time?)

Context _____
(Where were you at the onset of this pain/problem?)

Associated signs/symptoms _____
(What other associated problems have you been having?)

Modifying Factors _____
(What makes the pain/problem worse or better? Or have you had previous episodes?)

Past Medical History
Have you ever had the following: (Circle "no" or "yes". leave blank if uncertain)

Measles	No	Yes	Anemia	No	Yes	*Back Trouble	No	Yes	*Bleeding Tendency	No	Yes
Mumps	No	Yes	Bladder Infections	No	Yes	*High Blood Pressure	No	Yes	*Kidney Disease	No	Yes
Chickenpox	No	Yes	Epilepsy	No	Yes	*Low Blood Pressure	No	Yes	*Thyroid Disease	No	Yes
Whooping Cough	No	Yes	Migraine Headaches	No	Yes	*Hemorrhoids	No	Yes	*VRSA Dormant / Current	No	Yes
Scarlet Fever	No	Yes	*Diabetes Type:_____	No	Yes	*Date of last chest x-ray			*MRSA Dormant / Current	No	Yes
Diphtheria	No	Yes	*Tuberculosis	No	Yes	Hives or Eczema	No	Yes			
			*Cancer	No	Yes	*AIDS or HIV +	No	Yes			
Pneumonia	No	Yes	Polio	No	Yes	Infectious Mono	No	Yes			
Rheumatic Fever	No	Yes	Glaucoma	No	Yes	Bronchitis	No	Yes			
Heart Disease	No	Yes	*Hernia	No	Yes	*Mitral Valve Prolapse	No	Yes	*C-Diff Dormant / Current	No	Yes
Arthritis	No	Yes	Blood/Plasma Transfusion	No	Yes	*Stroke	No	Yes	Ulcer Type:_____	No	Yes
Venereal Disease	No	Yes	*Asthma	No	Yes	*Hepatitis	No	Yes			

Previous Hospitalizations/Surgeries/Serious Illnesses **When?** **Hospital, City, State**

_____ _____ _____
_____ _____ _____
_____ _____ _____

Medications: (Include prescription, over-the-counter medication, vitamins, supplements, diet medications, erectile dysfunction, medications, oils, etc)

Name **For What Reason Are you Taking?** **How Often?**

_____ _____ _____
_____ _____ _____
_____ _____ _____

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☐ Medication list attached

Allergies (include drug, environmental, food, animal, etc) **Reaction**

Patient social history: (Please circle)

Marital status:	Single	Married	Separated	Divorced	Widowed
Alcohol use:	Never	Rarely	Moderate	Daily	
Tobacco Use:	Never	Socially	Previously, but quit _____		Current packs /day _____
Drug Use:	Never	Frequency _____		Type _____	
Excessive exposure to	Fumes	Dust	Solvents	Noise	Airborne particles

Family Medical History

	Age	Diseases	If Deceased, Cause of Death
Father			
Mother			
Siblings			
Spouse			
Children			

Family History of Cancer: Yes No Type:_____ Relationship:_____
Type:_____ Relationship:_____
Type:_____ Relationship:_____

Work History

Occupation _____ Heavy Lifting Yes No If yes, _____ lbs

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Review of Systems: Please indicate any personal history below:

☐ **Constitutional Symptoms**			☐ **Gastrointestinal**			☐ **Musculoskeletal**		
Good general health lately	Yes	No	*Loss of appetite	Yes	No	Joint pain	Yes	No
*Recent weight change	Yes	No	*Change in bowel movements	Yes	No	Joint stiffness or swelling	Yes	No
*Fever	Yes	No	*Nausea or vomiting	Yes	No	Muscle pain or cramps	Yes	No
Chills	Yes	No	*Frequent diarrhea	Yes	No			
			Number of stools		_____	☐ **Integumentary (skin, breast)**		
☐ **Ears/Nose/Mouth/Throat**			Consistency		_____	Rash or itching	Yes	No
Hearing loss or ringing	Yes	No	How often		_____	Change in skin color	Yes	No
Earaches or drainage	Yes	No	*Constipation	Yes	No	*Breast pain	Yes	No
Chronic sinus problem/ rhinitis	Yes	No	*Rectal bleeding or blood in stool	Yes	No	*Breast lump	Yes	No
Nose bleeds	Yes	No	*Black tarry stool	Yes	No	*Breast discharge	Yes	No
Mouth sores	Yes	No	*Crohn's Disease	Yes	No			
Bleeding gums	Yes	No	*Ulcerative colitis	Yes	No	☐ **Neurological**		
Bad breath or bad taste	Yes	No	*Inflammatory	Yes	No	*Syncope	Yes	No
Sore throat or voice change	Yes	No				*Frequent of recurring headaches	Yes	No
Swollen glands in neck	Yes	No	☐ **Genitourinary**			Light headed	Yes	No
			Frequent urination	Yes	No	Convulsions or seizures	Yes	No
☐ **Cardiovascular**			Burning or painful urination	Yes	No	Head injury	Yes	No
*Heart trouble	Yes	No	Blood in urine	Yes	No			
*Chest pain or pressure	Yes	No	Kidney stones	Yes	No	☐ **Psychiatric**		
*Palpitation	Yes	No	*Female – pain with periods	Yes	No	Nervousness	Yes	No
*Shortness of breath w/walking			*Female – age of pregnancies		_____	Depression	Yes	No
or lying flat	Yes	No	*Female – date of last menstrual cycle		_____			
*Swelling of feet, ankles, hands	Yes	No	*Female – date of menopause		_____	☐ **Hematologic/Lymphatic**		
*Heart murmur	Yes	No				Slow to heal after cuts	Yes	No
			☐ **Respiratory**			*Bleeding of bruising tendency	Yes	No
☐ **Endocrine**			*Spitting up blood	Yes	No	*Anemia	Yes	No
*Thyroid disease	Yes	No	Shortness of breath	Yes	No	Past transfusion	Yes	No
*History of diabetes	Yes	No	*Wheezing	Yes	No			
*Family history of diabetes	Yes	No	Productive cough	Yes	No	☐ **Eyes**		
			*Sleep Apnea	Yes	No	*Wear glasses/contact lenses	Yes	No
						Blurred or double vision	Yes	No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____

Signature of Patient, Parent or Guardian Date

Doctor's Review

_____ _____

Signature of Doctor Date

Surgeons of
Lake County, LLC

Name:
Account:

Is your visit today related to an:

☐ Chief Complaint/Symptom
When did this problem begin: / /

☐ Injury
When did the injury occur: / /
Where did the injury occur: _____
Was the injury work related: ☐ Yes ☐ No

☐ Accident
When did the accident occur: / /
Where did the accident occur: _____
Was the accident work related: ☐ Yes ☐ No
Did another party cause your accident: ☐ Yes ☐ No

If another party is responsible for your medical bills due to an accident or work related injury, please provide us with the following information:

Name of adjuster/attorney _____

Address _____
_____

Phone Number _____

Fax Number _____

Claim/Reference # _____

I understand if I am unable to furnish Surgeons of Lake County and/or Emergency Surgical Services with this information, I will be responsible for all charges incurred. I give Surgeons of Lake County and its affiliate permission to send copies of my bills and to speak with the above named adjustor or attorney regarding my medical charges related to the above mention accident/injury.

_____ _____
Test Test Date

Surgeons of
Lake County, LLC

I, _____, understand that it is my responsibility to notify Surgeons of Lake County, LLC of any insurance changes prior to my procedure/surgery. Failure to do so, may result in my surgery or procedure being cancelled or may result in me being financially responsible for the entire charges related to my surgery or procedure.

I also understand that most insurance companies require prior authorization or pre-certification for procedures/surgeries. I understand it is necessary that the office must be provided current insurance information at minimum two weeks prior to my scheduled procedure/surgery to avoid any cancellations or insurance denials.

_____ _____

Signature Date

Surgeons of
Lake County, LLC

Release of Confidential Health Information

I, _____, hereby authorize:

_____
(Name of Health Care Facility, Physician, Agency, etc.)

_____
(Street Address, Suite Number, City, State, and Zip Code)

_____
(Telephone Number)

to release to:

Surgeons of Lake County, LLC
1870 W Winchester Road, Suite 112
Libertyville, IL 60048

the information contained in the patient record of

Name: _____ Birthdate: _____

The following information is authorized for release:

- ☐ Entire Medical Record
- ☐ Laboratory Reports
- ☐ X-ray Reports
- ☐ Operative Reports
- ☐ Other: _____

The purpose(s) of the authorization is (are) _____

I understand that this authorization is valid until is expires, unless revoked before that. I understand that I may revoke this authorization at any time by giving written notice to the physician of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to disclose my health information. Written revocation must be sent to the physician's office. Absent such written revocation, this Authorization for Release of Confidential Health Information will terminate on _____.

Signed: _____ Date: _____

If you are not the patient, please specify your relationship to the patient _____.