Chicago Cardiology Institute Patient Information Form

First Name:_____

Middle Initial:_____

Last Name:_____

Address:_____

Address 2:_____

City:_____

State:_____ Zip:_____

Leave Message

Home Phone:_____ ❒ Yes ❒ No

Day Phone:_____ ❒ Yes ❒ No

Cell Phone:_____ ❒ Yes ❒ No

Primary Contact #: Home / Cell / Work

E-mail address:_____

(Requested for access to online medical records and billing)

Emergency Contact

Name:_____

Relation:_____

Phone:_____

Date of Birth:_____

Social Security #:_____

Primary Care Physician:_____

Referred by:_____

Please Check Choice

Gender: ❒ Male ❒ Female

Status: ❒ Married ❒ Single ❒ Divorced ❒ Widow

Smoke: ❒ Yes ❒ No

Race: ❒ American Indian or Alaska Native ❒ Asian

❒ Black or African American

❒ Native Hawaiian or Other Pacific Islander

❒ White ❒ Declined to Answer

Ethnicity: ❒ Hispanic or Latino
❒ Non-Hispanic or Non-Latino
❒ Declined to Answer

Preferred Language:_____

Employment Information

Employment: ❒ Full ❒ Part ❒ Not employed

Occupation:_____

Employer:_____

Address:_____

Work Phone:_____

Insurance Information

If other than Self - Primary Cardholder: _____ Date of Birth: _____

Insurance Primary_____ Policy #:_____

Insurance Secondary_____ Policy #:_____

Assignments of Benefits

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare and other government sponsored programs, private insurance and any other health plans to Chicago Cardiology Institute or Dr. Parag Doshi. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits.

Signature:_____ Date:_____

Chicago Cardiology Institute

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Chicago Cardiology Institute ("the practice") may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to our Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent.

Chicago Cardiology Institute reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

Chicago Cardiology Institute
Attn:Chief Operating Officer
804 East Woodfield Road, Suite 300
Schaumburg, IL 60173

With my consent, and in accordance with Illinois law, Chicago Cardiology Institute staff, may contact me by phone, mail, e-mail, by a message on voice mail or in person, in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations. Treatment, payment and healthcare operations include: appointment reminders, insurance items, information regarding clinical care, including test results. I have the right to request that the practice restrict how it uses or discloses my Protected Health Information to carry out treatment, payment and healthcare operations. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to the practice's use and disclosure of my protected health information to carry out treatment, payment and healthcare operations. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, the practice may decline to provide treatment to me.

Please list anyone you give our office permission to talk to on your behalf.

_____

Name Relationship: Family/Caregiver/Friend

_____

Name Relationship: Family/Caregiver/Friend

_____

Name Relationship: Family/Caregiver/Friend

I have received a copy of the Notice of Privacy Practices for Chicago Cardiology Institute.

_____

Signature of Patient or Legal Guardian

_____ _____

Patient's Name Date

_____

Print Name of Patient or Legal Guardian

Rev 111312

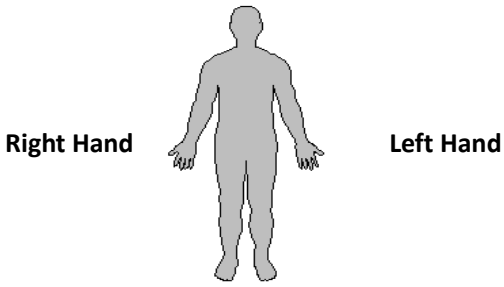
Peripheral Vascular Questionnaire

Your Name_____ Today's Date_____

Peripheral Vascular Disease is a common circulation problem in which the blood vessels, which carry blood to the legs and/or arms, become narrowed or clogged. Please fill out the questionnaire to help us identify if you have symptoms of Peripheral Vascular Disease. Circle **Yes** or **No** to the following questions:

1. Do you experience aching, cramping or pain in your arms, legs, thighs or buttocks when you walk or exercise?…… Yes No

   If you answered "yes" to question number 1, circle the area of the body on the diagram below where you feel pain:



2. If you answered "yes" to question number 1, does the pain go away with rest?…… Yes No
3. Do you have numbness and tingling in the arms or lower legs and feet?……. Yes No
4. Are your fingers or toes pale, discolored, or bluish?…… Yes No
5. Are your hands or feet cold to the touch?…… Yes No
6. Do you have open sores or ulcers on your legs or feet that won't heal?……. Yes No
7. Do you exercise on a regular basis?……. Yes No

   If not, what keeps you from exercising?_____

8. Do you have a family history of diabetes or cardiovascular problems (Immediate family: parent, sister, brother)? …… Yes No
9. Have you had any previous surgeries and/or angioplasty on the arteries in your legs, arms, kidneys, or brain?…….. Yes No

   If yes, describe the procedure; where and when it was performed:_____

Chicago Cardiology Institute's Financial Policy

CCI's mission is to provide the highest levels of compassionate care and service with the latest state of the art technology for the diagnosis and treatment of vascular disease. We are dedicated to serving you with respect and personal attention. Our non-surgical approach provides our patients with substantially lower cost procedures, significantly less risks, quicker recovery times and less patient discomfort.

We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc).

Please do not discuss /negotiate your co-pay or deductible amounts with your provider.

Co-pays
The patient is expected to present an insurance card at each visit whether you are seeing a Physician, a Physicians Assistant or a Nurse Practitioner. All co-payments and past due balances are due at time of check-in unless previous arrangements have been made with a billing coordinator. We accept cash, check or credit cards. Absolutely no postdated checks will be accepted. Failure to pay at time of visit may cause your appointment to be rescheduled and may be subject to a $10.00 billing fee.

Insurance Claims
It is your responsibility to make sure we are a participating provider with your plan. We will bill your primary and secondary insurance for you upon receipt of a valid insurance card. In order to properly bill your insurance company we require that you disclose all insurance information including primary and secondary insurances, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately. If an insurance carrier has not paid your services within 45 days of billing, we will transfer the balance to you for payment in full.

Referrals
Our office will attempt to get prior authorization from your Primary Care Physician or your Insurance Company for you. However it is ultimately your responsibility to make sure that there is a referral in place. In the event this information is not received we may cancel your appointment or request that you sign a waiver accepting responsibility for payment. Failure to obtain the referral and/ or preauthorization may result in a lower or no payment from the insurance company, and the balance will be your responsibility.

Self-pay Accounts
Self-pay accounts are patients without insurance coverage, patients covered by insurance plans in which the office does not participate, or patients without an insurance card on file with us. It is always the patient's responsibility to know if our office is participating with their plan. If there is a discrepancy with our information, the patient will be considered self-pay unless otherwise proven. Self-pay patients will be required to pay the balance in full at the time of visit. Extended payment arrangements are available if needed. Please ask to speak with a billing coordinator to discuss a mutually agreeable payment plan. It is never our intention to cause hardship to our patients, only to provide them with the best care possible and the least amount of stress.

Workers' Compensation and Automobile Accidents
In the case of a workers' compensation injury or automobile accident, you must obtain the claim number, phone number, contact person, and name and address of the insurance carrier prior to your visit. If this information is not provided, you will be asked to either reschedule your appointment or pay for your visit at the time of service.

Cancellation / Missed Appointment Policy
Our office requires a 24 hour notice for the cancellation of appointments. Appointments missed without required notice may be subject to a $30.00 fee.

Disability Insurance Form Completion
Our office will complete your disability insurance claim forms. The fee for each form is $15.00 and must be paid when the form is dropped of or at the time you receive your completed form. If you have asked us to mail your form directly to your insurance company, you will be required to pay the $15.00 fee when you drop the form off at our office.
PLEASE ALLOW 5-7 DAYS FOR COMPLETION OF YOUR DISABILITY FORMS. There will be an additional $10.00 charge for forms to be completed in 48 hours or less.

Charges That You May Be Responsible For:

Missed Appointments:	$30.00
Finance Charge for	$10.00
Copays: Disability Forms:	$15.00
Returned Checks (NSF):	$35.00 in addition to the insufficient funds amount.

Medical Records:

Patients:
$10.00 – Under 20 pages
$15.00 – 21 – 49 pages
$20.00 – Over 50 pages

Attorneys and insurance companies will be charged a $15.00 fee, plus postage and:
$.25 per page < 100 pages.
$.10 per page > 100 pages.
$15.00 for itemized bill
A special handling fee of $10.00 will be charged for records to be delivered in less than 48 hours.

Overpayments
Any credit under $20.00 will be held on the patients account to be credited to a future charge. Any amount over $20.00 will be refunded in the form of a check.

Payment Arrangements
We will allow you to carry a balance on your account upon approval of one of our Payment Arrangement Plans. You may be required to provide us with a credit card for automatic monthly withdrawals.

Collection Agency
We refer all unpaid accounts over 60 days past due to a third party collection agency unless the account has been approved for payment arrangements. The undersigned also agrees to pay any additional charges related to the cost of collections of for the account, including, but not limited to, collection agencies commissions and reasonable attorney's fees and costs of suit which are incurred by Chicago Cardiology Institute and Chicago Vascular Clinic in enforcing payment in the event that the undersigned fails to pay bills. The undersigned patient and/or guarantor authorizes Chicago Cardiology Institute to prepare and submit credit charge slips using any of the charge cards listed below to recover all charges and all other unpaid amounts due to the patient's failure to pay bills in a timely manner. The undersigned acknowledges that any payments made by the undersigned after collection efforts have begun shall first be applied against costs of collection, as described above and then to the principal balance due.

Acknowledgement
I acknowledge full financial responsibility for services provided to me by Chicago Cardiology Institute. I understand that I am responsible for prompt payment of any portion of the charges not covered by insurance, including co-payments, coinsurance and deductibles. I understand co-payments are due at the time of service as well as any prior balance I may owe. I understand that under provisions of HIPAA (The Health Insurance Portability and Accountability Act of 1996), my insurance company and/ or employer group plan administrator may be notified if I fail to fulfill my financial obligations for the payment of deductibles and co-insurance. I agree to all reasonable attorney fees and collection costs in the event I default on payment of my charges. I also consent that direct payment of authorized insurance benefits are paid on my behalf to Chicago Cardiology Institute.

Patients Name (Please Print): _____

Patients Signature: _____ Date: _____