Suburban Surgical Care Specialists, S.C.

James M. Kane, Jr., MD, FACS, FASMBS Peter C. Rantis, Jr., MD, FACS, FASCRS, FASMBS
Paul J. Guske, MD, FACS, FASMBS Jonathan W. Wallace, MD, FACS, FASMBS Frank K. Liao, MD, FACS

Demographics

First Name: _____ Middle Name: _____ Last Name:_____

Date of Birth: ____/_____/_____ Sex:_____ Language:_____Translator? Y or N (please circle)

Phone: _____-_____-_____ or _____-_____-_____E-mail:_____

Can we leave medical information?: ☐ Text ☐ Phone ☐ Both

Street Address:_____

City:_____ State:_____ Zip Code: _____

Marital Status:_____Race: _____Religion:_____ Ethnicity:_____

Primary Care Provider:_____ Referring Provider:_____

Pharmacy:_____ Street: _____City:_____

Emergency Contact Name: _____Relationship:_____

Phone: _____-_____-_____ Can release medical information? Yes_____No_____(please check)

Emergency Contact Name: _____Relationship:_____

Phone: _____-_____-_____ Can release medical information? Yes_____No_____(please check)

Employed: ☐ Yes ☐ No Occupation:_____ Employer:_____

If you will be filing Workers Compensation, see our staff for more information.

Primary Insurance:

Insurance Company: _____ Phone: _____-_____-_____Effective:_____/_____/_____

Primary Insured's Name: _____ Date of Birth: ____/____/____SSN_____

Employer's Name _____ Relationship to Patient: _____

Policy/I.D.#: _____ Group #: _____

Secondary Insurance: (if applicable)

Insurance Company: _____ Phone: _____-_____-_____Effective:_____/_____/_____

Primary Insured's Name: _____ Date of Birth: ____/____/____SSN_____

Employer's Name _____ Relationship to Patient: _____

Policy/I.D.#: _____ Group #: _____

I certify that the information provided on this form is true, complete, and accurate to the best of my knowledge. I authorize the office and its authorized personnel to enter, maintain, and update my demographic/medical/and insurance information for purposes of treatment, payment, and healthcare operations. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including MEDICARE, private insurance, and any other health plans to: Suburban Surgical Care Specialists, S.C. The assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as an original.

Patient Signature: _____ Date: _____/_____/_____

Guarantor Signature (if other than patient): _____ Date: _____/_____/_____

Suburban Surgical Care Specialists, S.C.

Financial Policy

Thank you for choosing Suburban Surgical Care Specialists, S.C. (SSCS).
We work hard to provide the highest quality of care.

QUESTIONS ABOUT THIS POLICY? Contact our Billing Department: 847-255-9697.
SSCS complies with Federal civil rights laws and does not discriminate based on race, origin, age, disability, or sex.

Insurance Billing & Financial Responsibility

- The patient, parent, legal guardian, or guarantor signing this policy agrees to be financially responsible for all services and supplies provided by SSCS, including deductibles, copayments, coinsurance, non-covered services, and other applicable charges. The signer also agrees to be responsible for applicable attorney fees and collection costs incurred by SSCS to collect outstanding balances, as permitted by law.
- Patients must provide **accurate and current insurance information** before services are rendered. SSCS will submit claims to the insurance company and may verify coverage and provide an estimate of the patient's financial responsibility. SSCS may require payment of some or all of the estimated amount before services are provided. The final patient's responsibility may change after the insurance claim is processed. Any remaining balance will be billed to the patient, and any credit balance resulting from claim processing will be refunded within 30 days.
- A 2.99% convenience fee applies to credit card transactions only and does not apply to debit card transactions. SSCS accepts cash, checks, and money orders.

Insurance & Managed Care

- Your insurance policy is a contract between you and your insurance company. You are responsible for all charges incurred. You must notify SSCS immediately regarding any changes in insurance.
- As owner of the policy, you are responsible for verifying that we are an in-network provider. **HMO** members are responsible for obtaining required referrals. If you do not have the required referral, you may be rescheduled and/or be responsible for charges your insurance does not cover.
- All copayments/other payments required by your plan, are *required* to be paid at the time of service. If you are unable to pay copay at time of service, your appointment may be **rescheduled**.

Medicare

- SSCS accepts Medicare assignments. As a Medicare patient, for covered services, you are responsible for the deductibles and co-insurance amounts as determined by Medicare. If you have supplemental insurance, we will bill the secondary carrier. If you do not have supplemental insurance the coinsurance and/or any unmet deductible may be due at time of service.
- Once claims are processed, you will receive a statement for any outstanding patient responsibility. If SSCS believes, your care will not be covered by Medicare, an Advanced Beneficiary Notice will given. In such case payment will be due at time of service.

Self-Pay	Collections
Self-pay patients are required to pay for services at time of visit or prior to procedure.	In the event of nonpayment, SSCS may recover applicable collection expenses, including court costs and reasonable attorney fees, as permitted by law. If your account is referred to collections or SSCS is notified of your bankruptcy filing, your physician may dismiss you from the practice, as permitted by law.

Fees & Cancellations

Cancellations must be made at least 24 hours before the appointment time.

NSF / returned check fee	$35
FMLA forms	$35
No-show — office visit	$35
No-show — scheduled procedure	$250

Patient Acknowledgement

By signing below, I acknowledge that I have read and understand this financial policy. I understand I can receive and ask for a copy of SSCS Notice of Privacy Practices during or after treatment.

Patient Name: _____ **Date:** _____

Patient / Parent / Guardian Signature: _____

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Personal Medical History

Please list name, dose and frequency of medication. Match medication to the medical condition you take it for.

Medication:_____ **Condition taken for:**_____

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Medication:_____ **Condition taken for:**_____

Medication:_____ **Condition taken for:**_____

Medication:_____ **Condition taken for:**_____

Medication:_____ **Condition taken for:**_____

Medication:_____ **Condition taken for:**_____

Medication:_____ **Condition taken for:**_____

Additional Medication and Vitamins:

_____

_____

_____

Allergies:_____

Additional Medical Condition you did not list above:

☐ Anemia ☐ Anxiety/Depression ☐ Arthritis ☐ Asthma ☐ Atrial Fibrillation ☐ Autoimmune ☐ BPH/Enlarged Prostate ☐ Blood Clots ☐ Cancer: Type_____ ☐ CVA/Stroke ☐ COPD/Emphysema ☐ CAD/Heart Disease ☐ Crohn's Disease ☐ Diabetes: Type____ ☐ GERD/Acid Reflux ☐ Hepatitis: Type_____ ☐ High Cholesterol ☐ High Blood Pressure ☐ Irritable Bowel Disease ☐ Liver Disease: Stage_____ ☐ Migraines ☐ Heart Attack ☐ Osteoarthritis ☐ Osteoporosis ☐ Renal Disease: Stage_____ ☐ Seizure Disorder ☐ Thyroid Disease ☐ Other:_____

Reason for visit, associated symptoms and any testing performed: _____

_____

_____

_____

_____

_____

Surgical History or Hospitalization:

☐ Angioplasty ☐ Appendix ☐ Arthroscopy knee ☐ Back Surgery ☐ Breast Augmentation ☐ Breast Reduction ☐ Bilateral Tubal Ligation ☐ CABG (open heart) ☐ Carpal tunnel release ☐ Cataract ☐ Cesarean section ☐ Cholecystectomy(gallbladder) ☐ Colectomy (colon removed) ☐ Colonoscopy ☐ Colostomy ☐ Duodenal Switch ☐ Gastric bypass ☐ Hernia repair ☐ Hip replacement ☐ Hysterectomy ☐ Knee replacement ☐ LASIK ☐ Liver biopsy ☐ Mastectomy ☐ ORIF (repair broken bone) ☐ Pacemaker ☐ Small bowel resection ☐ Thyroidectomy ☐ Tonsillectomy ☐ Prostatectomy ☐ Vasectomy ☐ Other: _____

_____

Last Colonoscopy: _____ **Provider that performed**: _____

Family History:

Relationship	Autoimmune	Cancer	Diabetes	Heart Problems	High Cholesterol	High Blood Pressure	Kidney Disease	Liver Disease	Mental Illness	Stroke
Mother										
Father										
Sibling										
Grandparent										
Child										
Uncle										
Aunt										

Other family history: _____

_____

_____

Social History:

Smoke or use smokeless tobacco?

☐Never ☐Previously ☐Current

Quit Date: _____Pack/day: _____

Drink alcohol?

☐Never ☐Previously ☐Current

How often do you drink? ☐ Less than once/mo ☐2-4x/mo ☐2-3x/week ☐Most days

Do you use drugs?

☐Never ☐Previously ☐Current

Type of drug(s) used: ☐ Benzodiazepines ☐ Ecstasy ☐ Cocaine ☐ Heroin ☐ Marijuana ☐ Methamphetamine ☐ Opioids

Authorization:

To the best of my knowledge, the questions on this form have been accurately answered. It is my responsibility to inform the medical office of any changes in my medical status. By signing I allow SSCS to access any/all external medical records including prescriptions and enroll in the e-prescribe program.

Patient Name: _____ **Date:** _____

Patient / Parent / Guardian Signature: _____

Physician Signature: _____