Advanced Medical Care LTD
SANDY POINT MEDICAL CENTER
290 NORTH RAND ROAD SUITE A
LAKE ZURICH. IL 60047
RAYMOND BIANCHI, MD JEANENE CACCOPOLA
847-438-4028

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

Name: _____

Phone:_____

Relationship to above: _____

Signature: _____

Date: _____

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: _____Cell Phone: _____

Signature: _____

Date: _____

WELCOME TO ADVANCED MEDICAL CARE

PATIENT INFORMATION

1. Patient Name	14 ☐ Married ☐ Single ☐ Other
2. Address	15 ☐ Part Time Student ☐ Full Time Student
3. City, State	☐ Unemployed ☐ Employed ☐ Retired ☐ Other
4. Zip Code	16 Referring Physician
5. Telephone No. / 5a. Cell Phone No.	17 If not referred by a physican who referred you:
5b. Email Address	☐ Friend Name _____
6. Previous Physician	☐ Newspaper
7. Social Security No.	☐ Radio
8. Employer Name & Address & phone number	☐ Community Event _____
9. Language spoken at home	☐ Yellow Pages
	☐ Other _____
10. Ethnicity / 11. Race	18 Who is financially responsible for the bill
12. Patient Sex / 13. Birthdate	☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Child ☐ Other

FINANCIALLY RESPONSIBLE PERSON (If different than above)

1. Financially Responsible Person (Name)	6. Employer Name
2. Address	7. Employer Address
3. City, State	8. Employer Phone No.
4. Zip Code	9. Social Security No.
5. Telephone No.	10. Birthdate / 11. Sex
Other Address (Seasonal)	

INSURANCE COMPANY INFORMATION

1. **Primary** Insurance Company Name	5. Address
2. Holder of Policy / 2a. Date of Birth *	6. City, State, Zip
3. Policy No. / 4. Group No.	4a. Social Security No.*
1. **Secondary** Insurance Company Name	5. Address
2. Holder of Policy / 2a. Date of Birth *	6. City, State, Zip
3. Policy No. / 4. Group No.	4a. Social Security No.*

ADVANCED MEDICAL CARE **PATIENT HISTORY**

Patient Name:_____ Date_____ DOB_____

Current Medications: Are you allergic to any medications ☐ Yes ☐ No

_____ _____ _____

_____ _____ _____

_____ _____

Describe problem you are being seen for today Pharmacy Name _____

_____ Pharmacy Phone No _____

Are you Disabled ☐ Job Related ☐ Military Have you been previously treated for this problem ☐ Yes ☐ No

PATIENT HISTORY

Anemia	☐ Yes
Arthritis	☐ Yes
Rheumatoid Arthritis	☐ Yes
Asthma/Emphysema	☐ Yes
Back Disorders	☐ Yes
Bursitis	☐ Yes
Bleeding Disorders	☐ Yes
Cancer?	☐ Yes
Diabetes	☐ Yes
Heart Disease	☐ Yes
Hepatitis	☐ Yes
High Blood Pressure	☐ Yes
HIV (Aids)	☐ Yes
Kidney Infection	☐ Yes
Kidney Stone	☐ Yes
Lung Disease	☐ Yes
Paralysis	☐ Yes
Phlebitis	☐ Yes
Pneumonia	☐ Yes
Rheumatic Fever	☐ Yes
Stroke	☐ Yes
Throid Disease	☐ Yes
TB	☐ Yes
Other	☐ Yes

_____

_____

_____

_____

_____

_____

REVIEW OF SYSTEMS

Prior Problem/Risk of Anesthesia	☐ Yes
Diseases of Eyes Nose or Throat	☐ Yes
Sinusitis	☐ Yes
Loss of Hearing	☐ Yes
Indigestion, Heartburn	☐ Yes
Hiatal Hernia	☐ Yes
Peptic Ulcer	☐ Yes
Stomach Pain	☐ Yes
Gallbladder Disease	☐ Yes
Bowel Disease (i.o Colitis, Diverticulitis)	☐ Yes
Intestinal Bleeding	☐ Yes
Frequent Urination	☐ Yes
Burning on Urination	☐ Yes
Difficulty Urinating	☐ Yes
Psoriasis	☐ Yes
Shortness of Breath	☐ Yes
Chills or Fever	☐ Yes
Hear/Chest Pain	☐ Yes
Angina	☐ Yes
Abnormal Heart Beat	☐ Yes
Muscle Weakness	☐ Yes
Joint Pain/Swelling	☐ Yes
Calf Cramps Walking	☐ Yes
Recent Weight Loss	☐ Yes
Leg/Skin Ulcers	☐ Yes
Mental Illness	☐ Yes
Addiction	☐ Yes
Gout	☐ Yes

SOCIAL HISTORY

Married☐ Single☐ Divorced☐

Number of Living Children?____

Presently living alone? _____

Do You Smoke? _____

Alcohol ☐ Never ☐Occasional ☐ Moderate to Heavy

Drug Overuse ☐ Never ☐ Present ☐ Past

Previous Surgeries

Tonsils	☐
Gallbladder	☐
Appendix	☐
Prostrate	☐
Hysterectomy/ovaries	☐
Cancer	☐
Back/Disc	☐
Fracture	☐
Heart	☐
Transplant	☐
Other	☐
List:	☐

_____

_____

_____

_____

_____

_____

_____

FAMILY HISTORY - *If a member of your family has had a history of any of the following conditions please check the box*

Stroke	☐	Aids/TB	☐	Other ☐	**Major cause of death**
Heart Trouble	☐	Bleeding Disorder	☐	Explain all Yes Answers:	Cancer
High Blood Pressure	☐	Alcoholism	☐	_____	Diabetes
Diabetes	☐	Seizures	☐	_____	Heart Disease
Arthritis	☐	Mental Illness	☐	_____	Hypertension
Gout	☐	Kidney Trouble/Stones	☐	_____	Accident
Cancer	☐	Leukemia	☐		

Reviewed with patient by _____

Advanced Medical Care, 290 N. Rand Road, Suite A, Lake Zurich, IL 60047
847.438.4028 Office, 847.438.2462 Fax, advmedcare@comcast.net

PATIENT AUTHORIZATION AND 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 are my sole responsibility.

I hereby authorize Advanced Medical Care, Inc. and it's designated agents to:

1. Bill my insurer and receive payment directly for all services rendered on my behalf.
2. Bill me for any amounts not paid by my insurer, including co-payments, deductibles, and non-covered services. I understand that 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.
3. Bill me directly for any services denied by my insurance for pre-existing conditions.
4. Bill me directly for any services not paid within sixty (60) days from 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 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 reasonable related to the above enumerated activities

Liability Release

I authorize 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 06/18/2012

ADVANCED MEDICAL CARE

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 disclosed 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 health care 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 a 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 receive an accounting of disclosures of 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.

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

Robin Davis, Privacy Officer
290 N. Rand Road, Suite A
Lake Zurich, IL 60047

Phone: 847 438-4028
Fax: 847 438-2462
E-mail: advmedcare@comcast.net

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 service 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

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Advanced Medical Care
290 N. Rand Road, Suite A
Lake Zurich, IL 60047
847 438.4028 office, 847 438-2462 fax

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 _____

Relationship to Patient: _____

Signature: _____

Date _____

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:

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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.

Advanced Medical Care, Ltd.

Raymond S. Bianchi, M. D. Jeanene M. Caccopola, D. O.

290 N. Rand Road, Suite A, Lake Zurich, IL 60047

847.438.4028 Office 847.438.2462 Fax

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 practice, 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 carrier requires that you obtain a referral from your Primary Care Physician (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 other parties involved, at the time of your appointment. You will be responsible for 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 work place, please be sure to contact your employer and inform them of your injury. We will need to receive 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.

"No Show" appointment: A charge of $25.00 for regular appointments and $50.00 for complete/surgical physicals will be added to your statement for not calling the office within 24 hours to cancel an appointment that you are unable to make.

Insurance requirement for preapproval of medication (this is not refills):	**$20.00**
Insurance requirement for preapproval of diagnostic testing:	**$30.00**

Insurance Appeal: A charge of $25.00 will be added to your statement for insurance appeal for **denying** diagnostic testing and denying medication by your insurance company

Convenience Fees: The phone fees listed below are for patients that do not wish to come in for follow up visits from nurse only lab work or diagnostic imaging!!!!

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

Phone call from 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)

Phone call from doctor regarding lab: **$60.00/call**
(This fee will only be charged when a patient comes in to have his or her labs drawn with the nurse and does not want to follow up with the doctor but wishes to have the doctor call them. This fee covers the time allotted for the above phone call include: physician receiving the results, interpreting the results, comparing these results with past results, making a diagnostic decision and treatment plan, conveying this treatment plan to the patient)

Phone call from doctor regarding diagnostic test results: **$60.00/call**
(This fee will only be charged if a patient does not want to come in for a follow up appointment after the tests have been done and wishes the doctor to call them with the results. This fee covers the time allotted for the above phone call include: physician receiving the results, interpreting the results, comparing these results with past results, making a diagnostic decision and treatment plan, conveying this treatment plan to the patient)

Patients with frequent lab/diagnostic results may be interested in purchasing one of the next two packages:
8 calls from nurse for lab or diagnostic results for patient/family **$150.00**
8 calls from doctor for lab or diagnostic results for patient/family **$360.00**

E-mail correspondence from the nurse (no consultations) **$20.00**

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 note that you will be responsible for your co-pay for these appointments.

Disability Forms, Letters and any other form: A charge of $25.00 to $50.00 for the completion of medical forms (charge is based upon number of pages and complexity of information requested). Payment is due at the time that you pick up the forms. Please allow 7 workdays for the completion of these forms. If you would like the forms to be mailed to you or the insurance company, payment will be due prior to us mailing them

X-Rays: All x-rays are the property of Advanced Medical Care LTD. You may sign out the original x-rays so that you may 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 radiologists report when available.

Late Fees: A $10.00 late fee per month will be applied to all balances 60 days past due.

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