NORTHWEST SUBURBAN UROLOGISTS **NAME** _____
DATE _____ **DATE OF BIRTH** _____

PAST HISTORY: (circle where indicated)
Illnesses: Please circle if you have had any of these health problems

Rheumatic fever	Scarlet fever	Pneumonia	Jaundice	Cancer	Ulcers
Anemia (low blood)	Arthritis	Emphysema	Diabetes	Heart disease	Stroke
High blood pressure	Asthma	Tuberculosis	Seizures	High cholesterol	
Bleeding tendency	Parkinson's	Nervous disorder			

Please list other (non-surgical) illnesses requiring hospitalization: _____
_____

OPERATIONS: Please circle if you have had surgery on: tonsils appendix uterus gall bladder
Other operations? Please date and list: _____
_____

MEDICATION ALLERGIES: Please (circle) No medication allergies Penicillin Sulfa
Iodine (x-ray dye) seafood
Others? _____

SPECIAL NEEDS: Please (circle) Wheelchair bound Use a walker

IMPLANTS OR FOREIGN BODIES : Please (circle) No Yes
If Yes, what kind and what year _____

SYSTEM REVIEW: Please (circle) Weight loss? Your present weight_____ Present height_____
Heart or lung trouble? Chest pain? Shortness of breath? Smoke? Cough?
Neuromuscular problems? Seizures? Are you nervous? Dizzy spells? Stroke? Depressed?
GI: Constipation? Blood in stool? Gastric distress? Irritable bowel?
EENT: Recent onset of headaches? _____ Eye problems? _____ Glaucoma? _____
For women only: # of pregnancies _____ # of miscarriages _____ Vaginal discharge _____
Pain with intercourse _____ Last menstrual period (date or years) _____
Other problems? _____

FAMILY HISTORY: How many brothers &/or sisters _____ Any ill or deceased? _____
Mother: Alive or deceased (circle) Cause of death and age _____
Father: Alive or deceased (circle) Cause of death and age _____
Please (circle) if any blood relatives (not yourself) have had these problems:

Birth defect of kidney or bladder	Urinary problems	Cancer	Diabetes
High blood pressure	Kidney stones	Cancer of prostate	Bleeders

Other health problems? _____

SOCIAL HISTORY:
Your usual occupation _____ Retired: yes/no
# of sons _____ ages _____ # of daughters_____ ages _____
Spouse's health _____ Spouse's occupation _____

HABITS: Please (circle)
Smoke: No Quit? When (date and year) _____
Yes How many packs of cigarettes per day? _____ How many years? _____
Alcohol: No/Yes Heavy Moderate Light Occasionally # shots/beers per day? _____
Recovering alcoholic (or other drugs)? _____

NORTHWEST SUBURBAN UROLOGISTS NAME: _____

DATE OF BIRTH: _____
TODAY'S DATE: _____

ALLERGIES: _____

INITIAL VISIT MEDICATIONS

Please list all prescription medications, herbal remedies, and over the counter drugs that you are currently taking. For example: Aspirin, Tylenol, glucosamine, vitamins, etc.

To be updated by medical staff

FOLLOW UP MEDICAL HISTORY

Date of Visit	New Medications (Started or stopped)	New Medical Problems or Surgeries

NORTHWEST SUBURBAN UROLOGISTS, LTD.
FINANCIAL POLICY

Northwest Suburban Urologists, Ltd. welcomes you to our practice. We are committed to providing you with the best possible care. 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 contact our billing office if you have any questions about fees or our Financial Policy. We request payment for services and office visits at the time the service is rendered. Our contract for services is with you, and it is our policy that you are responsible for our fees regardless of insurance coverage, or lack of it, or any arbitrary determination by your insurance company of usual and customary rates. We are committed to providing the best treatment possible for our patients and we charge what is usual and customary for our area.

1. **Full payment is due at the time of service. We accept cash, checks, payable to NORTHWEST SUBURBAN UROLOGISTS, LTD., mastercard, visa, discover and debit cards.**
2. Please remember to bring your insurance card and photo ID on the day of your first visit and every visit thereafter.
3. We are a participating provider for many HMOs and PPOs. Patients will not be billed for their care provided that we have the necessary referral form from the primary care physician. Any copayments you have with your insurance will be payable at the time of service. Co-pay is _____.
4. It is the patient's responsibility to call their insurance carrier to obtain pre-certification if required. If you are unsure whether pre-certification is a requirement, please contact your insurance carrier.
5. There will be a $ 40.00 service charge for ANY returned check.
6. All account balances older than 120 days will be sent to our collection agency and will be subject to 25% of any additional collection fees.
7. We accept Medicare assignment. As a Medicare patient, you are responsible for your annual $110.00 deductible as well as the difference between the approved charge and the amount Medicare pays.
8. Public Aid (PA) patients without valid IDPA cards will be responsible for visits until a valid ID care is provided. A $2.00 co-pay is due for each visit.
9. Secondary insurance: If we have information regarding your secondary insurance carrier at the time of service, we will as a courtesy submit to your secondary insurance carrier.
10. There is a $30.00 charge for appointments that are not cancelled within a 24 hour notice.
11. There will be a 1.5% interest charge on all patient balances over 90 days.

We must emphasize that as a Medical care provider, our relationship is with you, not your insurance company. We realize that temporary financial problems may affect timely payments of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. If you have any questions about the above information, please do not hesitate to call us at 847-823-3321.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any services rendered. I have read all the information on this sheet.

Signature _____ Date _____

Parent (if minor) _____ Date _____

NORTHWEST SUBURBAN UROLOGISTS, LTD

INSURANCE ASSIGNMENT & RELEASE OF INFORMATION

PATIENT NAME:_____

It is our office policy to inform you of our patient payment procedure. Please review the section below that is applicable to you.

- ❑ **1. Patient with Insurance**

You are responsible for deductibles; co-pays, non-covered services, coinsurance and items considered "not medically necessary" by your insurance company. Please pay co-payments and coinsurance amounts as services are rendered. The remaining balance should be taken care of within one (1) month of notice from insurance company. If you or your insurance carrier makes payment exceeding your balance, reimbursement will be remitted. If payment cannot be made at each visit, notify the front –desk staff to make other arrangements.

- ❑ **2. Worker's Compensation Patient**

  As a Worker's Compensation patient you may be covered by insurance if your injury is reported at work and verified with your employer. Be sure to inform the office personnel that your injury resulted during employment. ***Patient is Ultimately Responsible for Balance. After a 6 month period patient will be expected to start a payment plan.***

- ❑ **3. Personal Injury (Accident)**

  If you are a personal – injury patient, our office will bill the appropriate insurance companies. ***If we are unable to obtain payment, the charges for the services rendered will be your responsibility.*** Please give all information needed for billing. If an attorney is involved and asks you not to submit insurance claims, a doctor's lien must be signed by you and your attorney. ***After a 6 month period patient will be expected to start a payment plan.***

- ❑ **4. Medicare**

Our office will submit your Medicare charges to WPS Medicare and your secondary insurance. You are responsible for deductibles, co-pays, and any non-covered services.

ASSIGNMENT

- ❑ I request that payment of authorized Medicare benefits be made on my behalf to Northwest Suburban Urologists, LTD for any service furnished me by that provider. Medicare Number _____
- ❑ The signature below authorized payment of mandated Medigap benefits to Northwest Suburban Urologists, LTD. Medigap_____Policy Number_____
- ❑ I assign the benefits from my insurance carrier(s) to this clinic for the medical/surgical benefits I am entitled to.

RELEASE OF INFORMATION

- ❑ I authorize Northwest Suburban Urologists, LTD to release to my insurance carrier(s) and / or CMS (formerly HCFA) and its agents and / or my Medigap insurer any information needed to determine benefits or benefits payable for related services.

I have read and agree to the Financial Policy, Assignment, and Release of Information paragraphs stated above that apply to me.

Patient or responsible party signature Date

Northwest Suburban Urologists, LTD
Communication Waiver

Excellent communication is a very important part of providing quality health care. In an effort to provide you with the timeliest information regarding your health care, we ask that you complete this waiver.

We normally contact our patients between 9:00 am and 5:00 pm. During this time, what is the phone number that we should use to contact you?

(____)_____Home Work Cell (please circle the location)

If a call is necessary outside of these hours, what is the phone number that we should use to contact you?

(____)_____Home Work Cell (please circle the location)

E-mail address_____

If you are unavailable at the time we contact you, may we leave medical information with another person?

Yes No (Please Circle)

Whom_____

If you are unavailable at the time we try to contact your, may we leave medical information on your voice mail?

WORK	Yes	No
HOME	Yes	No
CELLULAR	Yes	No

May we leave medical information on e-mail? Yes No (Please Circle)

******PLEASE NOTE – We DO NOT accept any emergency or medical questions by e-mail or fax. These are not monitored for this type of information and may lead to a delay in medical treatment of your problem. Please call 847 823 3185. ******

_____

Name Please Print

_____

Signature Date