SUBURBAN LUNG ASSOCIATES ***History Form***

PATIENT NAME _____Date_____ Sex M F

Current Medications

Name	*Dose*	*Frequency*	*Name*	*Dose*	*Frequency*

Allergies to Medications	*Type of Reaction*	*Allergies (Other)*	*Type of Reaction*

Past Medical History

Medical Problem	*Date*	*Surgical Procedure*	*Date*

Hospitalization	*Location*	*Date*

Tests and Immunizations

Item (Most Recent)	*Yes*	*Year*	*No*
Chest X-Ray/Chest			
EKG			
Exercise Treadmill			
Allergy Skin Testing			
Flu Vaccine			

Item (Most Recent)	*Yes*	*Year*	*No*
Pneumonia Vaccine			
Pulmonary Function			
Sleep Study			
Sinus X-Ray/CT			
TB (PPD) Skin Test			

Family History

System	Diseases	Family Member/Age
Respiratory	**Emphysema/COPD**	
	Asthma	
	TB	
	Other	
Heart	**Heart attack**	
	Heart bypass surgery	
	Valvular heart disease	
	Hypertension	
	Stroke	
Endocrine	**Diabetes**	
	Thyroid	
	Other	
Cancer	**Lung**	
	Breast	
	Gastrointestinal	
	Other	

Social History

Past/Present Occupations:

Smoking History **Number of cigarettes/packs per day: _____**
Cigars Y N
Number of years smoked _____
If quit, (Date) _____

Alcohol History **Number of drinks per day/week: _____**

Marital Status: **S M D W**

Highest level of education:

Pets:

Exercise:

With whom do you live?

Patient Name _____ Date _____

Revised 10/02

CHICAGO CHEST CENTER
INTERVENTIONAL PULMONOLOGY & THORACIC DISEASE

SUBURBAN LUNG
SLEEP LUNG ALLERGY
ASSOCIATES

CHICAGO SLEEP GROUP

Name:		**Patient ID #:**	104075 **Sex:** [ ]M [ ]F
Address:		***Preferred Language**	
Address:		**Race**	
City,State, Zip:	,	**Ethnicity**	
Date of Birth:		**Preferred Method of Contact :** (Phone) (Letter) :	
Phone 1:	[ ]Home [ ]Work [X]Mobile	**e-Mail address**	
Phone 2:	[ ]Home [ ]Work [X]Mobile	**Referring Dr. & Phone:**	
Social Security #:		**Primary Dr. & Phone**	
Marital Status:	[ ]Married [ ]Single [ ]Divorced [ ] Widowed	**I authorize Release of Information to (you may designate 1 or 2 persons):**	
Emergency Contact	**Phone**	**ROI 1**	
		ROI 2	

RESPONSIBLE PARTY (If other than patient)

Name:		**Relationship to Patient**	[ ]Same as Patient
Address		**Social Security**	
City,State, Zip:		**Birthdate**	
Phone		**Employer:**	
Drivers License #		**Employer Phone**	

INSURANCE INFORMATION

PRIMARY INSURANCE:		***SECONDARY INSURANCE:***	
[ ]Patient [ ]Spouse [ ]Insured Party		[ ]Patient [ ]Spouse [ ]Insured Party	
Insured Party:		**Insured Party:**	
Ins Company:		**Ins Company:**	
Relationship to Patient:		**Relationship to Patient:**	
Social Security #:		**Social Security #:**	
Insured ID:		**Insured ID:**	
Policy Group:		**Policy Group:**	
Date of Birth:		**Date of Birth:**	
Insured Phone:		**Insured Phone:**	

I hereby authorize Suburban Lung Associates, SC to release any medical records related to my care in order to obtain payment for medical services rendered on my behalf. I also authorize Suburban Lung Associates, SC to submit all charges for services rendered to me and assign any benefits payable to Suburban Lung Associates, SC. I understand that I am responsible for any portion of my bill not covered by insurance companies, governmental agencies or their intermediaries, or third party payors. I understand that co-pays and balances are due at the time of the visit. This information is valid for (1) one year and will be updated annually. I have read and understand the Patient Responsibilities provided to me. **HIPAA** I hereby acknowledge receipt of the physician's Joint Privacy Notice. I understand that Suburban Lung Associates, SC has reserved the right to change their privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available.

Signature_____Date_____

* English is spoken by Staff. Please bring a translator if you need assistance.

02/24/2014

REGISTRATION AND FINANCIAL POLICY

Thank you for choosing ***Suburban Lung Associates*** as your medical specialist. We are committed to providing high-quality, cost-effective health care. As part of our service to you and your family, we have summarized your financial responsibilities below.

INSURANCE

Our staff will file your insurance claim, for covered services, including Medicare, Public Aid and Worker,s Comp. We appreciate in over 40 health plans, however it is your responsibility to verify coverage **PRIOR** to your appointment. We will hold incomplete claims for 5 business days only. If you have not provided accurate information within 5 business days the full amount will be your responsibility. A copy of your driver,s license and insurance card(s) will be made upon registration.

REFERRALS

We **DO NOT** accept faxed referrals. You **MUST** bring an original referral to you appointment. If you do not have the required authorization, you will be asked to sign a referral waiver. This places you responsible for the full amount due until an original referral is received.

DEDUCTIBLES AND COPAYS

Many health plans require the patient to meet an annual deductible and often have routine copays for physician services. Check with your health insurance for specific details on the amount. Deductibles and copays are due at the time of service.

PAYMENT

Patient balances will be collected at the time of service. For your convenience we accept cash, check, or credit card (Master Card, VISA, Discover). A $15.00 charge will be assessed for all checks returned for “Insufficient Funds.”

PAST DUE BALANCES AND COLLECTIONS

Our staff will assist you in making payment as easy as possible. Although we understand emergencies and hardship, we have a legal responsibility to collect on overdue accounts. Please contact the patient Accounts Department if you have extenuating circumstances. Payment arrangements for financial hardship may be considered but not guaranteed. Accounts more than 6 months old may be sent to collections.

MISSED APPOINTMENTS

Certain diagnostic tests require medication to be specifically mixed for each patient. Once mixed, these medications may be not be reused. If you are scheduled for a test in this category and need to reschedule please call at least 24 hours in advance. Otherwise a fee for the medication will be charged to your account.

PROTOCARE

A protocare staff member may contact me now or in the future for possible Clinical Research opportunities.

I have read and understand ***Suburban Lung Associates Financial Policy***.
Signature indicated on reverse side of form.