

Specialty Care Institute

ENT, Sinus & Hearing

Patient Registration Form

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

Street Address: _____

City: _____ State: _____ Zip Code: _____

SSN: _____ - _____ - _____ Birth Date: _____ Gender: Male/ Female Age: _____ Marital Status: S M W D

Please circle one: (We are required by law to ask for the information below.)

Race: American Indian, Asian, Native Hawaiian, African American, White, Hispanic, Other, Refuse to Report

Ethnicity: Hispanic or Latin, Not Hispanic, Refuse to Report Language: English, Spanish, Other _____

Email address: _____ (Allows consent for e-mail from our office)

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer: _____ Occupation _____

Pharmacy Name _____ City _____ State _____

Intersection _____ Phone: _____ Mail order Pharmacy: _____

Emergency Contact Name: _____ Relation: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Primary Insurance: _____ ID #: _____

Group Number: _____ Name of Insured: _____

SSN of Insured: _____ Birth Date of Insured: _____ Relationship to Insured: _____

Secondary Insurance: _____ ID#: _____

Group Number: _____ Name of Insured: _____

SSN of Insured: _____ Birth Date of Insured: _____ Relationship to Insured: _____

How did you hear about us? Doctor Referral _____ Dr's Phone # _____

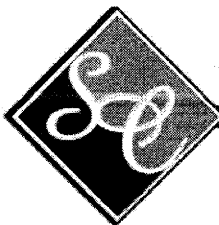
Patient Referral _____ Other _____

When canceling or rescheduling an appointment, 24 hour notice must be given or a \$35 NO SHOW/CANCELLATION fee will be applied to my account. Patient Initials _____

I, the undersigned, grant permission to *Specialty Care Institute* to disclose medical information to other treating physicians regarding my care. I authorize the release to the Health Care Financing Administration or said insurance company and its agents any medical information about me to determine benefits payable for related services. I understand that, I the undersigned am legally responsible for all fees related to medical services rendered, including copayments, coinsurance and deductibles.

Patient's Signature

Date



Specialty Care Institute

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I, _____, HAVE BEEN GIVEN THE OPPORTUNITY TO READ A COPY OF SPECIALTY CARE INSTITUTE'S NOTICE OF PRIVACY PRACTICES.

X _____

Signature of Patient

X _____

Date

If you are not the patient, Please specify your relationship to the patient:

PATIENT COMMUNICATION AUTHORIZATION

Person(s) Authorized to received information about my healthcare

Name: _____ Relationship: _____ Date of Birth: ____/____/____

Name: _____ Relationship: _____ Date of Birth: ____/____/____

Name: _____ Relationship: _____ Date of Birth: ____/____/____

Name: _____ Relationship: _____ Date of Birth: ____/____/____

I authorize physicians and staff to communicate and/or leave messages for me at:

Home: Yes _____ No _____ Number _____

Work: Yes _____ No _____ Number _____

Cell: Yes _____ No _____ Number _____

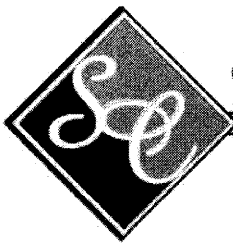
Text Message: Yes _____ No _____

Mail: Contact me at this address: _____

I authorize Specialty Care Institute to send marketing materials to:

My Home Address: Yes _____ No _____ Email: Yes _____ No _____

Other requests for Confidential Communications:



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Name _____
Birthdate ____/____/____

Medications and Medical History

LIST OF CURRENT MEDICATIONS

<u>NAME</u>	<u>DOSE</u>
1) _____	_____
2) _____	_____
3) _____	_____
4) _____	_____
5) _____	_____
6) _____	_____
7) _____	_____
8) _____	_____
9) _____	_____
10) _____	_____

LIST ALLERGIES TO MEDICATIONS No known drug allergies

<u>NAME</u>	<u>REACTION</u>
1) _____	_____
2) _____	_____
3) _____	_____
4) _____	_____
5) _____	_____

<u>PREVIOUS INJURIES</u>	<u>APPROXIMATE DATE</u>
1) _____	_____
2) _____	_____
3) _____	_____
4) _____	_____

<u>PREVIOUS SURGERY</u>	<u>YEAR</u>	<u>HOSPITAL</u>
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____
4) _____	_____	_____
5) _____	_____	_____

DO YOU HAVE ANY OF THE FOLLOWING MEDICAL PROBLEMS?

- Arthritis High Blood Pressure High Cholesterol Kidney Disease Thyroid disease
- Blindness Glaucoma Diabetes Cancer Heart Disease
- Asthma Seizures Hearing Loss Bronchitis Colitis
- Stroke Tuberculosis Other _____

Do you Smoke? No ½ Pack Daily 1 Pack Daily More Former, Quit date _____

How much alcohol do you drink? None Rarely Socially Daily



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REVIEW OF SYSTEMS

Are you currently, or have you had, problems with:

Name _____
Birthdate ____/____/____

Constitutional *Circle One*

Weight gain	Yes	No
Weight loss	Yes	No
Night sweats	Yes	No
Insomnia	Yes	No

Eyes

Tearing/burning/itching	Yes	No
Crossed eye/lazy eye	Yes	No
Glaucoma	Yes	No
Cataract	Yes	No
Injuries	Yes	No
Macular Degeneration	Yes	No

Allergic/Immunologic

Sneezing	Yes	No
Itchy eyes/nose	Yes	No
Itchy throat	Yes	No
Skin rash	Yes	No
HIV	Yes	No

Ear, Nose, Throat and Mouth

Hearing loss	Yes	No
Noise/ringing in ears	Yes	No
Nasal congestion	Yes	No
Nasal drainage	Yes	No
Sore throat	Yes	No
Trouble swallowing	Yes	No
Hoarseness	Yes	No

Endocrine

Diabetes	Yes	No
Thyroid disease	Yes	No

Respiratory

Asthma	Yes	No
Coughing up blood	Yes	No
TB	Yes	No
Pneumonia	Yes	No
Trouble breathing at night	Yes	No
Snoring	Yes	No

Cardiovascular

Chest pain or angina	Yes	No
Heart trouble	Yes	No
Rheumatic fever	Yes	No
Heart murmur	Yes	No
High blood pressure	Yes	No

Gastrointestinal

Indigestion or heartburn	Yes	No
Ulcer	Yes	No
Hepatitis	Yes	No
Jaundice	Yes	No
Blood in stool	Yes	No
Black, tarry stools	Yes	No

Hematologic

Bleeding disorder	Yes	No
Easy bleeding	Yes	No

Genitourinary

Bladder trouble	Yes	No
Prostate disease	Yes	No
Kidney disease	Yes	No

Musculoskeletal

Arthritis	Yes	No
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Neurological

Numbness	Yes	No
Weakness	Yes	No
Stroke	Yes	No
Headache	Yes	No

Psychiatric

Depression	Yes	No
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IS THERE A FAMILY HISTORY OF THE FOLLOWING MEDICAL PROBLEMS? (Please specify family member)

- | | |
|--|---|
| <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Tuberculosis _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> High Blood Pressure _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Seizures _____ |
| <input type="checkbox"/> Hearing Loss _____ | <input type="checkbox"/> Thyroid Disease _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Macular Degeneration _____ |
| <input type="checkbox"/> Blindness _____ | <input type="checkbox"/> Colitis _____ |
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Bronchitis _____ |
| <input type="checkbox"/> Stroke _____ | <input type="checkbox"/> Kidney Disease _____ |
| <input type="checkbox"/> Glaucoma _____ | <input type="checkbox"/> High Cholesterol _____ |

The above information is accurate to the best of my knowledge.

Patient Signature _____

Date _____



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PATIENT FINANCIAL POLICY

Patient Name: _____ Birthdate: ____/____/____

Thank you for choosing Specialty Care Institute for your medical care. We are committed to the success of your medical treatment and care. Please understand that a mutual financial understanding is part of our relationship.

We sincerely hope that by sharing our financial expectations we will strengthen the practice-patient relationship and keep the lines of communication open. This financial policy helps the practice provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact our office manager at 847-888-9000.

Payment is Due At the Time of Service

- We accept cash, checks, debit, and credit cards.
- All co-payments, deductibles and non-covered services are due at the time of service unless you have made payment arrangements in advance of your appointment.
- **Insurance required co-payments are due when you check in for your appointment.** If you arrive without your co-payment, we may ask you to reschedule. We charge an administration fee of \$25.00 for co-payments not paid at the time of check in.
- If your co-payment is based on a percentage (example: 20% of the allowed payment) and you do not have a secondary policy, please be prepared to pay a minimum of \$40.00 on the date of service.
- Patient-responsible balances are due when you check in for your appointment.
- In the event you need surgery and you do not have health insurance coverage, we must receive down payment of no less than 50% of the estimated doctor's fees before we will schedule the surgery.
- We request that at least **24 hour** advance notice be given to the office if you will be unable to keep your scheduled appointment. All cancellations with less than 24 hours notice and no-shows will be billed \$35.00 per occurrence. Patients will be expected to pay the \$35.00 fee prior to, or at the time of their next appointment. If we need to bill you, the \$25.00 administrative fee will be applied in addition to the cancellation/no-show fee. Patients who repeatedly "no show" for appointments may be discharged from the practice.
- There is a \$25.00 fee for checks returned non-sufficient funds

Proof of Insurance

- Please bring your insurance card(s) and a valid photo ID with you to each appointment.
- It is your responsibility to notify the practice of changes in your health insurance.

Self Pay

- We designate accounts, **Self-Pay**, under the following circumstances: (1) patient is covered by an insurance plan that our physicians do not participate in, (2) patient does not have a current, valid insurance card on file, (3) patient does not have a valid insurance referral on file, or (4) patient does not have health insurance coverage.

Referrals

- If you have an HMO plan we are contracted with, you need a referral authorization from your primary care physician. It is your responsibility to call our office 24-48 hours prior to your appointment to see if we have received your referral. If we have not received an authorization prior to your arrival at the office, call your primary care physician to obtain it. If you are unable to obtain the referral at that time, you will be rescheduled or asked to pay for the visit in advance.

Patient/Guarantor Signature _____ Date _____



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PATIENT FINANCIAL POLICY

Our Responsibility to Report Non-Compliance

- It is our obligation under many of the insurance contracts to report patients who: repeatedly refuse to pay co-payments/deductibles at time of service, or who repeatedly "no show" for appointments. \

Divorce and Child Custody Cases

- In cases of divorce, the individual who receives care is responsible for payment of co-payments, coinsurance, deductibles, and nonparticipating insurance balances at the time of service. We will not bill a divorced spouse for the patient's services.
- The parent who brings the child to the office for care is responsible for payment at the time of service no matter if the account is self-pay, participating insurance, or nonparticipating insurance. The practice does not honor divorce specifics (e.g., *percentage of financial responsibility*).
- If the child has coverage with a participating insurance plan and the proper insurance identification is present at the time of service, the practice will bill that insurance company. Applicable co-payments, coinsurance and/or deductibles are due at the time of service, unless arrangements have been made with the office prior to arrival.

Billing, Payments and Refunds

- All balances are due in full within 14 days of the statement date.
- If you cannot pay the balance in full with 14 days, please contact our billing department to see if you qualify for special payment options.
- It is your responsibility to notify the office of any change in address, phone, employment, or insurance coverage.
- If you make an overpayment on your account, we will issue a refund only if there are no other outstanding debts on other accounts with the same guarantor or financial responsible party.
- We reserve the right to report delinquent accounts to credit bureaus, assess a collection fee, take other collection action, or terminate you as a patient of this practice.

I authorize my insurance benefits be paid directly to Specialty Care Institute.

I authorize Specialty Care Institute, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

I authorize Specialty Care Institute to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility.

Patient/Guarantor Signature _____ Date _____

Elgin: 1750 N Randall Rd., Ste 210, Elgin, IL, 60123
Barrington: 602 Fox Glen Ct., Barrington, IL, 60010
Hoffman: 3150 W Higgins Rd., Ste. 130, Hoffman Estates, IL, 60169

Phone Number: 847-888-9000
Fax Number: 847-888-9001
www.specialtycareinstitute.com



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Patient Name: _____ Date of Birth: _____ Date: _____

Hearing Health Questionnaire

The onset of hearing loss is usually very gradual. It may take place over 25-30 years, or it may happen more rapidly if you are exposed to loud noises at work or through hobbies. Because it usually occurs slowly, you may not even be aware that you have a problem until someone brings it to your attention. Here is a simple test you can take to determine if you have a hearing loss.

1. Do others complain that you watch television with the volume too high? Yes No
2. Do you frequently have to ask others to repeat themselves? Yes No
3. Do you have difficulty understanding what is being said
when in groups or noisy situations? Yes No
4. Do you have to sit up front in meetings, church or other social
gatherings in order to hear a speaker's words? Yes No
5. Do you have difficulty understanding women or young children? Yes No
6. Do you have trouble knowing where sounds come from? Yes No
7. Are you unable to understand when someone talks to you from another room? Yes No
8. Have others told you that you don't seem to hear them? Yes No
9. Do you avoid family gatherings or social situations because
you "can't understand"? Yes No
10. Do you have ringing or other noises (tinnitus) in your ears? Yes No

If you have answered yes to even one of these questions, you should have your hearing evaluated by an audiologist and take steps now to educate yourself about lifestyle changes you can make to slow the progression of hearing loss.