Progressive Surgical Associates

PATIENT INFORMATION

NAME (FIRST, MIDDLE, LAST)

DATE OF BIRTH

STREET ADDRESS

SOCIAL SECURITY NUMBER

CITY, STATE, ZIP

HOME PHONE

E-MAIL

CELL PHONE

EMERGENCY CONTACT AND RELATIONSHIP

EMERGENCY CONTACT PHONE

PATIENT EMPLOYER

PATIENT EMPLOYER PHONE NUMBER

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY

NAME OF POLICY HOLDER

RELATIONSHIP TO POLICY HOLDER

DATE OF BIRTH OF POLICY HOLDER

POLICY HOLDER EMPLOYER

POLICYHOLDER EMPLOYER PHONE NUMBER

SECONDARY INSURANCE COMPANY

NAME OF POLICY HOLDER

RELATIONSHIP TO POLICY HOLDER

DATE OF BIRTH OF POLICY HOLDER

POLICY HOLDER EMPLOYER

POLICYHOLDER EMPLOYER PHONE NUMBER

RACE/ETHNICIY

☐ AMERICAN INDIAN OR ALASKA NATIVE

☐ ASIAN

☐ NATIVE HAWAIIAN

☐ BLACK OR AFRICAN AMERICAN

☐ WHITE

☐ HISPANIC

☐ OTHER RACE_____

Staff only: _____

AUTHORIZATION TO TREAT
(Please initial each blank below)

I hereby authorize and consent to treat/care rendered to me by the physician/medical staff. _____

FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS

I have received and read "Our Financial Policy" and agree to the terms therein. I also understand and agree that such terms may be amended by the Practice from time to time. _____

Additionally, I authorize Progressive Surgical Associates to bill my insurance company on my behalf and accept payment from them directly. I know I am required to make any required co-payment amounts, as well as pay for any charges assigned to my deductible, or non-covered services, including an assistant for surgery. _____

PRIVACY PRACTICES AND AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I have received or I have been provided the opportunity to receive a copy of the "Notice of Privacy Practices" that explains when, where, and why my Protected Health Information (PIH), which may include information regarding HIV/AIDS status or mental health records, may be used or shared. _____

I hereby authorize my insurance carrier to furnish Progressive Surgical Associates any information obtained in the adjudication of any claim in regard to services furnished to me by them. This authorization is valid until rescinded by me in writing. I authorize Progressive Surgical Associates to furnish complete information, including Protected Health Information, requested by my insurance carrier or its intermediaries regarding services rendered. _____

I acknowledge that Progressive Surgical Associates (PSA), the physicians, the nurses, and other PSA staff may obtain and share any or all of my Protected Health Information with others in order to treat me, in order to arrange for payment of my bill and for issues that concern PSA's operations and responsibilities. _____

I further authorize the disclosure of my Protected Health Information to the following individuals/family members:

_____ _____
Name **Relationship to Patient**

_____ _____
Name **Relationship to Patient**

NOTICES AND PATIENT COMMUNICATIONS

You expressly consent to be contacted by Progressive Surgical Associates (PSA), or anyone calling on its behalf, for any and all purposes, at any telephone number, or physical or electronic address you provide or which you may be reached, including any wireless telephone number. You agree that PSA may contact you in any way, including calls or prerecorded or artificial voice or text messages delivered by an automatic telephone system dialing system, or e-mail messages delivered by an automatic e-mailing system. You expressly acknowledge that this consent cannot be revoked without prior agreement and acceptance by us. You agree to promptly notify us at any time your contact information changes.

X_____ _____
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY **DATE**

I give permission that Progressive Surgical Associates may:

☐ Leave a detailed message on my home/cell answering machine or voicemail
☐ Call my workplace phone number and leave a message
☐ Call my workplace phone number and only speak to me
☐ Send text/SMS messages about medical instructions or collecting payments
☐ None of the above

X_____ _____
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY **DATE**

Staff only: _____

NAME (FIRST, MIDDLE, LAST) _____ DATE OF BIRTH _____

PRIMARY CARE PHYSICIAN _____ WHO REFERRED YOU HERE TODAY? _____ CARDIOLOGIST _____

NAME AND LOCATION OF PREFERRED PHARMACY? _____

HEIGHT _____ ft _____ inches WEIGHT_____ lbs AGE _____

CURRENT MEDICATIONS

MEDICATION NAME	DOSAGE	FREQUENCY

ARE YOU TAKING ANY BLOOD THINNING MEDICATIONS, I.E., PLAVIX, COUMADIN, LOVENOX, ASPIRIN, IBUPROFEN, MOTRIN?

☐ YES ☐ NO IF YES, WHAT? _____

ARE YOU TAKING ANY DIET OR HERBAL MEDICATION?

☐ YES ☐ NO IF YES, WHAT? _____

PAST MEDICAL HISTORY

DO YOU HAVE OR HAVE YOU HAD:

- ☐ ABNORMAL HEART RHYTHM
- ☐ ANXIETY
- ☐ ARTHRITIS
- ☐ ASTHMA
- ☐ AUTOIMMUNE DISEASE :_____
- ☐ BLEEDING DISORDER
- ☐ BLOOD CLOTS
- ☐ CANCER, TYPE: _____
- ☐ CONGENTIAL ABNORMALITY
- ☐ DEPRESSION
- ☐ DIABETES
- ☐ ELEVATED CHOLESTEROL
- ☐ GERD/HEARTBURN
- ☐ FIBROMYALGIA
- ☐ HEART ATTACK
- ☐ HEART DISEASE
- ☐ HEART FAILURE
- ☐ HIGH BLOOD PRESSURE
- ☐ HIV/AIDS
- ☐ HYPERTHYROID
- ☐ HYPOTHYROID
- ☐ KIDNEY DISEASE
- ☐ LIVER PROBLEMS
- ☐ OSTEOPOROSIS
- ☐ PULMONARY EMBOLISM
- ☐ SEIZURE
- ☐ STROKE
- ☐ TUBERCULOSIS
- ☐ ULCER : _____
- ☐ OTHER: _____

Staff only: _____

DRUG ALLERGIES

PLEASE LIST ANY DRUG ALLERGIES AND REACTION:

_____ _____

_____ _____

PAST SURGICAL HISTORY

☐ APPENDECTOMY
☐ BACK SURGERY
☐ BREAST SURGERY
☐ COLON / RECTAL SURGERY
☐ COLONOSCOPY
☐ C-SECTION
☐ EGD (UPPER ENDOSCOPY)
☐ GALLBLADDER
☐ GASTRIC BYPASS / BANDING
☐ HEART BYPASS
☐ HEMORRHOID SURGERY/BANDING
☐ HERNIA REPAIR: _____
☐ HYSTERECTOMY (ABDOMINAL)
☐ HYSTRECTOMY (VAGINAL)
☐ JOINT REPLACEMENT
☐ OVARY REMOVAL
☐ TONSILLECTOMY
☐ OTHER: _____ _____

FAMILY HISTORY

DO YOU HAVE A HISTORY OF **CANCER** OR **HEART DISEASE** IN YOUR FAMILY? PLEASE LIST THE MEMBER AND THEIR CONDITION

_____

_____

SOCIAL HISTORY

OCCUPATION: _____

DO YOU DRINK ALCOHOL?

☐ **YES** (HOW MUCH?_____) ☐ **FORMERLY USED ALCOHOL** ☐ **NEVER USED ALCOHOL**

DO YOU SMOKE TOBACCO?

☐ **CURRENT SMOKER** (HOW MUCH?_____) ☐ **FORMER SMOKER?** (QUIT DATE_____) ☐ **NEVER SMOKED**

FOR WOMEN:

NUMBER OF PREGNANCIES _____ NUMBER OF LIVE BIRTHS _____

IN THE PAST 12 MONTHS HAVE YOU USED: (CIRCLE ONE, IF ANY)

COCAINE **MARIJUANA** **SPEED** **OTHER:** _____

Progressive Surgical Associates

REVIEW OF SYSTEMS

CONSTITUTIONAL SYMPTOMS

RECENT WEIGHT: GAIN / LOSS (circle)	☐ YES	☐ NO
FEVER	☐ YES	☐ NO
FATIGUE	☐ YES	☐ NO
HEADACHES	☐ YES	☐ NO

DERMATOLOGY

RASH OR ITCHING	☐ YES	☐ NO
VARICOSE VEINS	☐ YES	☐ NO

ENDOCRINE

GLANDULAR/HORMONAL PROBLEM	☐ YES	☐ NO
INTOLERANCE TO: HEAT / COLD (circle)	☐ YES	☐ NO
INSULIN PUMP	☐ YES	☐ NO

BREAST CONDITIONS

BREAST PAIN	☐ YES	☐ NO
BREAST LUMP	☐ YES	☐ NO
BREAST DISCHARGE	☐ YES	☐ NO

HEMATOLOGIC/LYMPHATIC

BLEEDING/BRUISING TENDENCY	☐ YES	☐ NO
ANEMIA	☐ YES	☐ NO
PHLEBITIS/BLOOD CLOTS IN LEGS	☐YES	☐NO
PAST TRANSFUSION	☐ YES	☐ NO

NEUROLOGICAL

CONVULSIONS OR SEIZURES	☐ YES	☐ NO
NUMBNESS OR TINGLING SENSATIONS	☐ YES	☐ NO
PARALYSIS	☐ YES	☐ NO
STROKE OR TIA	☐ YES	☐ NO

EYES

WEAR: GLASSES / CONTACTS (circle)	☐ YES	☐ NO
BLURRED OR DOUBLE VISION	☐ YES	☐ NO

EARS/NOSE/MOUTH/THROAT

HEARING LOSS OR RINGING	☐ YES	☐ NO
NOSEBLEEDS	☐ YES	☐ NO
SORE THROAT OR VOICE CHANGE	☐ YES	☐ NO

RESPIRATORY

ASTHMA	☐ YES	☐ NO
EMPHYSEMA	☐ YES	☐ NO
CHRONIC/FREQUENT COUGHS	☐ YES	☐ NO
TUBERCULOSIS	☐ YES	☐ NO
PNEUMONIA	☐ YES	☐ NO

CARDIOVASCULAR

HEART MURMUR	☐ YES	☐ NO
MITRAL VALVE PROLAPSE	☐ YES	☐ NO
RHEUMATIC FEVER	☐ YES	☐ NO
CHEST PAIN/ANGINA PECTORIS	☐ YES	☐ NO
PALPITATIONS (RAPID HEART BEAT)	☐ YES	☐ NO
PACEMAKER	☐ YES	☐ NO
STROKE	☐ YES	☐ NO
HISTORY OF HEART ATTACK	☐ YES	☐ NO

GASTROINTESTINAL

LOSS OF APPETITE	☐ YES	☐ NO
CHANGE IN BOWEL HABITS	☐ YES	☐ NO
NAUSEA	☐ YES	☐ NO
VOMITING	☐ YES	☐ NO
FREQUENT DIARRHEA	☐ YES	☐ NO
PAINFUL BOWEL MOVEMENTS	☐ YES	☐ NO
CONSTIPATION	☐ YES	☐ NO
RECTAL BLEEDING/BLOOD IN STOOL	☐ YES	☐ NO
ABDOMINAL PAIN	☐ YES	☐ NO
UNINTENTIONAL WEIGHT LOSS	☐ YES	☐ NO
JAUNDICE	☐ YES	☐ NO
VOMITING BLOOD	☐ YES	☐ NO
HISTORY OF LIVER DISEASE	☐ YES	☐ NO
HEARTBURN / ACID REFLUX	☐ YES	☐ NO

MUSCULOSKELETAL

JOINT PAIN	☐ YES	☐ NO
JOINT STIFFNESS OR SWELLING	☐ YES	☐ NO
WEAKNESS OF MUSCLE/JOINTS	☐ YES	☐ NO
BACK PAIN	☐ YES	☐ NO

PSYCHIATRIC

NERVOUSNESS	☐ YES	☐ NO
DEPRESSION	☐ YES	☐ NO
INSOMNIA	☐ YES	☐ NO
ANXIETY	☐ YES	☐ NO

GENITOURINARY

BLOOD IN URINE	☐ YES	☐ NO
INCONTIENCE OR DRIBBLING	☐ YES	☐ NO
KIDNEY STONE	☐ YES	☐ NO

My signature below signifies that the information provided in this document, which includes my medical history, is true and complete, to the best of my knowledge.

PATIENT SIGNATURE_____ **DATE**_____

Progressive Surgical Associates

PROGRESSIVE SURGICAL ASSOCIATES
CREDIT CARD POLICY

Progressive Surgical Associates (PSA) has implemented a new policy for all patients. If you wish to be seen by our practice, we will be requesting your credit/debit card information to keep on file to be used to cover any charges not paid by your insurance. Patients will still be expected to pay known co-pays, co-insurance and any applicable deductible at the time of service. If a balance remains after your insurance has paid, you will receive two statements for services in the month, which is due within 30 days.

It will be the responsibility of the patient to contact our office if there is any question regarding your claim, amount due, to set up a payment plan, or provide an alternate form of payment before 30 days. If we do not hear from you within 30 days, the balance on your account will be charged to your credit/debit card on file.

If you feel a charge has been made in error, please call our billing department at 815-717-8730. Please do not dispute the charge with your credit card company, or you will be charged a $150 fee.

Your credit/debit information will be kept with the highest level of security and will only be used for your medical expenses. Your credit card number cannot be viewed while in the system.

Your understanding of and patience with this new policy is very important. To be clear, no charges will be placed on your credit card until after your claim is settled with your insurance carrier and two statements have been mailed to you. If we do not hear from you within 30 days after this statement has been sent, we will charge your credit card.

My signature represents my understanding of the above policy. My signature authorizes PSA to maintain my credit/debit card information to be used for charges that are my responsibility, after insurance has paid their portion. My signature authorizes PSA to email a receipt of any transaction to the email on file in patient chart. I understand that this form is valid until I provide written notice that it is revoked (after any balance is paid in full). I also understand that if I change to a new credit/debit card, I will supply Progressive Surgical Associates with the new credit/debit card.

YOU WILL BE ASKED TO SIGN THE SIGNATURE PAD CONSENTING TO THIS POLICY WHEN YOU CHECK IN FOR YOUR APPOINTMENT.

Progressive Surgical Associates

OUR FINANCIAL POLICY

The staff at Progressive Surgical Associates is dedicated to providing the best possible care for you, and we want you to be aware of our financial policies to avoid any misunderstandings.

INSURANCE

As a courtesy, Progressive Surgical Associates verifies your benefits with your insurance company. We do this so that you:

- Will have an estimate of what your financial responsibility will be, and
- To determine what portion of your charges should be paid by you at or before the time of service.

A quote of benefits is not a guarantee of benefits or payment. Your claim will process according to your plan's formal regulations, regardless of any good faith quote you/we receive from your insurance prior to your care. Even if you/we have a quote, we cannot guarantee what your insurance company will pay. Therefore, you may receive a bill from us if the insurance company denies, changes, or reduces the payment for the services we provided you. You are financially responsible for all charges. If you authorize it, as a service to you, we will file your claim with your insurance so that your insurance company can pay us directly. We will also follow up for you, but if your insurance company does not pay the claim within a reasonable period, we will have to look to you for payment.

CO-PAYS / DEDUCTIBLES / CO-INSURANCES

All co-payments, deductibles, and co-insurances must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

If your insurance plan has a deductible you have not yet met (we will verify your coverage at the time of visit) you will be expected to pay the visit in full. We offer convenient payment plans.

CREDIT CARD POLICY

We accept Visa, MasterCard, Discover and American Express.

It is the policy of this office to keep a credit card on file for patients under active care. This is a convenient method of payment for the portion of services that your insurance does not cover, but for which you are liable. Furthermore, most insurance plans require deductibles and copayments that may not be known to you or us at the time of your visit.

Your credit card will only be used to pay account balances after insurance processing if/when:

- You instruct us to bill your credit card for any outstanding balance and/or
- Your balance is 60 days past due and we have sent you at least 2 statements and/or
- Your insurance card is invalid and you do not have additional insurance.

You will be notified prior to our making any charges to your credit card.

Medicaid patients will not be required to place a credit card on file due to federal regulations.

Progressive Surgical Associates

OUR FINANCIAL POLICY

SELF-PAY

If you do not have insurance, or if we cannot verify your coverage, payment is due at the time of service. We offer discounted pricing for self-pay visits and convenient payment plans. This self-pay discount is only available to uninsured patients; offering this discount to insured patients is a violation of your and our contract with your insurance.

CHECK POLICY AND RETURNED CHECKS

We accept personal checks for medical services. We do not accept checks for medical products available in our office. We will charge a fee of $35.00 for all checks returned unpaid.

MISSED APPOINTMENTS

We request a 24-hour notice for ALL office visit cancellations. $50.00 will be charged for all office visits missed or cancelled without a 24-hour notice. Missed/canceled surgeries without a 72-hour notice will be charged $150.00. Missed/canceled colonoscopies or EGDs without a 72-hour notice will be charged $150.00. These fees must be paid before scheduling your next appointment.

ADDITIONAL FEES & SERVICES

Patients may incur additional charges not covered by insurance for services like photocopying and filling out forms. While we are happy to provide this service, it makes a significant impact on our practice resources. In accordance with Illinois law, we charge:

- $15 for filling out of forms for employers, FMLA, disability, etc.
- For photocopying we charge:
  - $1.18 per page (pages 1-25)
  - $.79 per page (pages 26-50)
  - $.39 per page (over 50 pages)

The State of Illinois allows a Handling Charge of $31.56 in addition to the above per page fees, however, at this time, we will waive this fee as a courtesy to our patients.

COLLECTIONS

If your account is delinquent, we may file it with a collection agency to collect payment. If this becomes necessary, your account may be charged additional fees to offset some of the collection costs we incur.

Any account with an unpaid balance that is determined to be your responsibility by the insurance company may be sent to collections after 90 days from the Explanation of Benefits date. The collection agency is: Choice Recovery, and they can be reached at 614-358-9900 or toll free at 800-559-9277.

Progressive Surgical Associates

OUR FINANCIAL POLICY

* *

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

____

Signature of patient (or responsible party, if minor)

____

Please print the name of the patient

____

Date

* *

If you are having a surgery with an orthopedic surgeon and Dr. Gamagami:

I agree, if my insurance partially or completely denies my procedure or any component of it, I will be responsible for the charges:

____

Signature of patient (or responsible party, if minor)