

REVIEW OF SYSTEMS-LAKE COOK ORTHOPEDICS

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS? CIRCLE YES OR NO ON EACH ONE

PATIENT NAME: _____

PLEASE DO NOT CIRCLE YES OR NO IN GROUPS

ALLERGIC:

- 1. FREQUENT INFECTIONSYesNo
- 2. METAL ALLERGIESYesNo
- 3. SHELLFISH ALLERGIESYesNo
- 4. IODINE ALLERGYYesNo
- 5. LATEX ALLERGYYesNo
- 6. ANAPHYLACTIC REACTIONYesNo

CARDIOVASCULAR

- 7. CHEST PAINYesNo
- 8. RAPID HEART BEAT AT RESTYesNo
- 9. ANKLE SWELLINGYesNo
- 10. HIGH CHOLESTEROLYesNo
- 11. HEART MURMURYesNo
- 12. IRREGULAR HEARTBEATSYesNo
- 13. PAIN IN CALVES WITH WALKINGYesNo
- 14. VARICOSE VEINSYesNo
- 15. CALF CRAMPING AT NIGHTYesNo

CONSTITUTIONAL

- 16. FATIGUEYesNo
- 17. LOSS OF APPETITEYesNo
- 18. WEIGHT LOSSYesNo
- 19. FEVERYesNo
- 20. ACHE ALL OVERYesNo
- 21. SLEEP PROBLEMSYesNo

EAR, NOSE, THROAT

- 22. DIFFICULTY WITH HEARINGYesNo
- 23. RINGING IN THE EARSYesNo
- 24. FREQUENT BLOODY NOSESYesNo
- 25. SINUS PROBLEMSYesNo
- 26. LOSS OF SENSE OF SMELLYesNo
- 27. SORES IN MOUTHYesNo
- 28. INFECTED TEETHYesNo
- 29. BLEEDING GUMSYesNo
- 30. HOARSENESSYesNo
- 31. DIFFICULTY SWALLOWINGYesNo
- 32. SORE THROATYesNo
- 33. SWOLLEN GLANDSYesNo
- 34. SNORINGYesNo

ENDOCRINE

- 35. POOR HEALINGYesNo
- 36. EXCESSIVE APPETITEYesNo
- 37. HOT FLASHESYesNo
- 38. EXTREME THIRSTYesNo
- 39. EXCESSIVE HAIR GROWTHYesNo

EYES

- 40. BLURRED VISIONYesNo
- 41. DOUBLE VISIONYesNo
- 42. ABRUPT LOSS OF VISIONYesNo
- 43. GLASSESYesNo

GASTROINTESTINAL

- 44. PAIN IN STOMACHYesNo
- 45. DIARRHEAYesNo
- 46. NAUSEAYesNo
- 47. VOMITINGYesNo
- 48. BLOOD IN STOOLSYesNo
- 49. LOSS OF CONTROL OF BOWELSYesNo
- 50. DARK BLACK STOOLSYesNo

GENITOURINARY

- 51. IMPOTENCEYesNo
- 52. NEED TO URINATE OFTENYesNo
- 53. VAGINAL/PENILE DISCHARGEYesNo
- 54. BLOOD IN URINEYesNo
- 55. BURNING WITH URINATIONYesNo
- 56. LOSS OF CONTROL OF URINEYesNo

HEMATOLOGIC

- 57. EASY BRUISINGYesNo
- 58. BLEEDING PROBLEMSYesNo
- 59. SICKLE CELL DISEASEYesNo
- 60. ANEMIAYesNo
- 61. PREVIOUS BLOOD TRANSFUSIONSYesNo

INTEGUMENTARY

- 62. ACNEYesNo
- 63. BLISTERSYesNo
- 64. RASHESYesNo
- 65. PSORIASISYesNo
- 66. EXCESSIVE SCARRINGYesNo
- 67. SHINGLESYesNo

NEUROLOGICAL

- 68. HEADACHESYesNo
- 69. DIZZINESSYesNo
- 70. NUMBNESSYesNo
- 71. WEAKNESSYesNo
- 72. FORGETFULNESSYesNo
- 73. FAINTINGYesNo
- 74. TREMORSYesNo

PSYCHIATRIC

- 75. INSOMNIAYesNo
- 76. DEPRESSIONYesNo
- 77. SUICIDALYesNo
- 78. ADDICTION DISEASEYesNo
- 79. PANIC ATTACKSYesNo
- 80. VICTIM OF ABUSEYesNo
- 81. EATING DISORDERYesNo

RESPIRATORY

- 82. SHORTNESS OF BREATHYesNo
- 83. CHRONIC COUGHYesNo
- 84. COUGHING UP BLOODYesNo
- 85. SLEEP APNEAYesNo
- 86. SHORT OF BREATH WHEN LYING FLATYesNo

DATE: _____

X _____

Patient signature

PHYSICIAN INITIALS AND DATE: _____

Initials signify review of the data with the patient and agreement with the data.

Lake Cook Orthopedic Associates

PATIENT HISTORY FORM

Note to patients: We cannot adequately treat your problem without the information detailed below. The federal and state governments require that we be as complete as possible in our documentation of your medical record. Thank you for taking the time to fill out these forms.

Today's Date: _____ Family doctor: _____

Last Name: _____ First Name: _____ Middle: _____

Chief Complaint: What is the reason for your visit today?

*REASON: _____

History of Present Illness:

1. Location: Name area(s) involved: _____

2. Severity: (on a 1-10 scale with 10 being the worst): _____

3. Quality: Describe the problem: dull, sharp, etc. _____

4. Duration: How long has it been a problem: _____

5. Timing: When does your problem occur? _____

6. Context: Is the problem getting worse, better, unchanged? _____

7. Modifying factors: What makes it worse, or better? _____

8. Is this due to an injury? Yes No
If yes, complete the following:
Date of injury _____
Workmen's compensation? Yes No Are you off work? Yes No Date last worked _____
Auto Accident? Yes No

Medications

If yes, please list your medications and dosages, including vitamins and herbs. _____

Allergies

Do you have any allergies? Yes No
If yes, please list allergies and describe the reaction: _____

Past Medical History

Please circle yes or no if you have any of the following diseases:

- | | | | |
|-----------------------|-----------|-------------------------------|-----------|
| 1. Arthritis..... | Yes....No | 9. High Blood Pressure..... | Yes....No |
| 2. Asthma..... | Yes....No | 10. Kidney Disease | Yes....No |
| 3. Cancer..... | Yes....No | 11. Neurological Disease..... | Yes....No |
| 4. Diabetes..... | Yes....No | 12. Seizures..... | Yes....No |
| 5. Emphysema..... | Yes....No | 13. Stroke..... | Yes....No |
| 6. Glaucoma..... | Yes....No | 14. Thyroid Problem..... | Yes....No |
| 7. Heart Disease..... | Yes....No | 15. Stomach Ulcers..... | Yes....No |
| 8. Hepatitis..... | Yes....No | 16. Other, please list: _____ | |

Family Medical History

Please List any serious medical problems in your immediate family: _____

Past Surgical History

Please list any surgeries you have had done and the approximate year: _____

Social History

Do you work? Yes No
If yes describe your occupation: _____
Do you smoke? Yes No
If yes please list how much you smoke per day and for how long: _____
If no please state when you quit and how many pack years you have: (multiply the number of packs per day by the number of years you smoked)

_____ Do you drink alcohol? Yes No
If yes please list how much: _____

HEIGHT: _____ WEIGHT: _____

FOR WOMEN: IS THERE ANY CHANCE YOU ARE PREGNANT? Yes No

To the best of my knowledge all of the preceding answers are true and correct. If I have any change in my medical, I will inform Lake Cook Orthopedics at my next appointment, or by phone if no visits are scheduled. I understand that failure to disclose my medical condition may jeopardize my health.

I give my consent to any examination and any necessary X-rays.

Patient's signature: _____ Date: _____
(parent/legal guardian if patient is a minor)

Lake Cook Orthopedic Associates Notice of Privacy Practices (NPP) Summary

This page summarizes the six pages of Lake Cook Orthopedic Associates' Notice of Privacy Practices. We recommend that you read the entire NPP. The Health Information Portability Accountability Act requires us, as a health care provider, to give you a NPP.

The NPP describes how our practice uses and discloses your protected health information (PHI). This information is about you, as well as your demographics. It is used for the treatment and coordination of your health care by our staff and physicians. We may disclose your PHI in order to treat, diagnose, obtain payment for services, and from time-to-time to support our overall healthcare operations. Some uses and disclosures of your PHI may be made with your authorization, and you have the opportunity to object to the use or disclosure of all or part of your PHI. However, using our professional judgment, for example, in the time of emergencies, the physicians and staff can determine whether disclosure is in your best interest.

Again, we recommend that you read the following six pages of NPP carefully. Under HIPAA, the law requires you to sign this page acknowledging that you had the opportunity to read and receive a copy of the NPP.

Patient: _____

Sign: _____ Date: _____
Patient, Parent, or Legal Guardian

Print name: _____
Patient, Parent, or Legal Guardian

Financial Policy

Welcome to Lake Cook Orthopedic Associates. Your health is our primary concern. In order to serve you better, we need to work within the rules of many insurance plans. We have therefore developed a financial policy in an effort to anticipate most of the situations our patients might encounter.

Minor Patients:

We need permission from a child's parents (or guardians) in order to treat a child. Arrangements for payment must also be made, by the adult, within the following guidelines. These guidelines apply for all other (non-minor) patients as well.

Red Flag Rules:

It is the policy of Lake Cook Orthopedic Associates to follow all federal and state laws and reporting requirements regarding identity theft. Specifically, this policy outlines how LCOA will (1) identify, (2) detect, and (3) respond to "red flags." A "red flag" as defined by this policy includes a pattern, practice, or specific account or record activity that indicates possible identity theft.

When a patient calls to request an appointment, the patient will be asked to bring the following at the time of the appointment:

Driver's license or other photo ID;

Current health insurance card; and

Utility bills or other correspondence showing current residence if the Photo ID does not show the patient's current address. If the patient is a minor, the patient's guardian should bring the information listed above.

If the patient has not completed the registration form within the last six months, registration staff will verify current information on file and, if appropriate, update the information.

Insurance:

Many types of insurance are currently available. Some of our patients are insured under traditional insurance, HMOs (Health Maintenance Organizations), PPOs (Preferred Provider Organizations), workman's compensation, Medicare, Medicaid, or other varieties of insurance. Some patients are not covered by insurance.

Most insurance plans are contracts between a patient and the insurance company. The bills are the responsibility of the patient. As a courtesy, we will work with you to help you receive maximum benefits. Some parts of the fees are due at the time of service. Specifically, co-payments must be paid at the time of service. We will help you, by billing for you HMO, PPO, workman's compensation, Medicare (and any secondary

insurance), Medicaid and some other types of insurance. You must therefore bring the information needed to submit bills. This may include insurance cards, claim numbers, accident date, case manager's name and phone number, and any other identifying information. Details of the billing process for many insurance circumstances are outlined in the following sections.

If your insurance has not paid your account in full within 45 days, you are required to pay the outstanding balance. Accounts past due greater than 30 days will be assessed a \$5 service charge per month until fully paid.

Medicare:

If you are insured by Medicare or Medicare Railroad Retirement, we will bill for you. We will also bill your secondary insurance carrier after Medicare has sent an EOB (explanation of benefits). You must provide us with the insurance company's name, mailing address, policy/group number, identification number and where appropriate the claim number.

HMOs:

As specialists, we are on the panel of several HMOs, either through Advocate Health Partners or Tri County Physician's Association. Each HMO has its own rules, which you and we must follow. You are responsible for knowing the rules of your particular plan. Some general and common rules involve referrals and co-payments (co pays). We cannot see patients insured by HMOs without a "referral form". These come from your primary care physician and must be available at the time of your visit. They must include all the services you might need. For instance follow-up fracture care usually involves taking x-rays. Therefore your referral for a fracture follow-up visit must include authorization for x-rays. Primary care physician's offices are not always open at the time of your office appointment with us. Therefore, your referral form should be obtained prior to your appointment with us. You will usually need a separate referral for each visit with us. Co-payments are due at the time of your visit, so be prepared to pay them at that time. We will bill the HMO insurance for your charges. If you need other services (physical therapy, imaging studies, durable medical equipment, etc.) you will almost always require a referral for that also.

PPOs:

As specialists, we are on the panel of several PPOs (Preferred Provider Organizations). Each PPO has a predetermined fee schedule. And each PPO has different rules about co-payments, deductibles, precertification and coverage. You are responsible for knowing your plan's details. In most cases we will submit bills for you. All co-payments are due at the time of service.

Accident or Third Party:

If you have been injured and there is third party insurance, such as automobile insurance, your bills are your responsibility. We will help you file claim forms. You must provide us with the necessary information. Claim number, date of accident, insurance company

name and address, adjuster's name and contact information, and any other needed information must all be provided.

Workman's Compensation:

If you have been injured at work it is your responsibility to arrange for payment of your bill. We will help you file claim forms. You must provide us with the necessary information. Claim number, date of accident, insurance company name and address, adjuster's name and contact information, and any other needed information must all be provided.

Medicaid:

We do not accept Medicaid.

Public Aid from the State of Illinois has extremely poor reimbursement, notoriously burdensome paperwork and extreme delays in payment. Therefore we choose not to participate in it. This is within our right and within the law.

We are, however, very mindful of our duty to treat those seen in the emergency room when we are on emergency room call at Good Shepherd Hospital, which is the only hospital staff of which we are members. We will see patients from that institution's emergency room, but will determine ourselves the timeliness needed for each case based on our review of the facts as presented by the Good Shepherd Hospital Emergency Room staff and records.

We also choose to continue the time-honored tradition of charity care to give back to our community, as medical professionals have done for centuries. However we reserve the right to decide for ourselves the financial need and the patient's ability to pay, as any business would do if you were seeking secured or unsecured debt. The decision to grant charity will reside with the individual physician. We must note that we, as physicians, are one of the few institutions in our modern society that will give our services away for free for those in need, and we do so gladly. But we would ask that you, as the recipient of that gift realize you have not received an entitlement, but something we have given to you in your time of need. We will in many cases work out a payment plan based on your assets and your employment. We would only ask that you honor that pay schedule once it has been fairly determined by our billing staff and notify us when your financial situation has changed.

Change in Insurance Status:

If your insurance status changes, it may require extra insurance filing and work. For instance, you may first inform us to use your health insurance, and subsequently decide it should be filed as workman's compensation. There will be additional charges due at the time of the second filing in these circumstances. These fees will be commensurate with the work involved and start at \$50 per claim

Electronic Prescriptions:

Our electronic medical record program accesses your prescription/medication history in order for us to safely prescribe your medication. By signing this, you authorize us to do so.

Missed Appointments:

Unless canceled 24 hours in advance, our policy is to charge for missed appointments. Please help us serve you better by calling to cancel appointments. We can then use them for other patients. This will decrease the waiting time for appointments.

Unless other arrangements are made (as detailed in the preceding sections) FULL PAYMENT IS DUE AT THE TIME OF SERVICE. We accept cash, checks and credit cards (Visa/MasterCard/American Express).

ACKNOWLEDGEMENT:

I have read the above Financial Policy, which I understand and agree to.

X

Signature of Patient or Responsible Party

Date

Insurance Plans:

We currently are participating in the following insurance plans. Insurance companies, from time to time change their networks. When you call for your appointment we can help you determine whether we are in your network.

Aetna
Blue Cross/Blue Shield
Cigna
Coresource (Advocate Employees)
Great West
HFN
HMO Illinois
Humana
Medicare
United Healthcare
Most Worker's Compensation Plans (check with our office)

New Patient Forms:

For your convenience, you may download our new patient forms prior to your appointment. You may then fill them out at your leisure at home in advance. You will have access to information at home that you might need to complete the forms. Please fill them out completely.

If you have x-rays, MRI scans, CT scans, old records, or other pertinent information, please bring that along to your visit.

Office Locations:

Barrington: Suite 125
Smith Professional Building
27401 West Highway 22
Barrington, IL 60010
Telephone 847 381 0388
Fax 847 381 0811

Algonquin: 2294 County Line Road
Algonquin, IL 60102

Lake Zurich: Suite 100
350 Surryse Road
Lake Zurich, IL 60047

Please call the main office for appointment scheduling

Physical Therapy:
Suite 225

Lake Barrington Fieldhouse
28156 West Northpointe Parkway
Lake Barrington, IL 60010
Telephone 224 512 9800
Fax 224 512 9714

The major map websites such as Mapquest do not show the correct locations for our offices. Please use the map below for directions.

PLEASE PRINT

MR.
MRS.
MISS

PATIENT LAST NAME FIRST NAME MIDDLE

SOCIAL SECURITY # DATE OF BIRTH AGE DRIVERS LICENSE #

ADDRESS APT # CITY STATE ZIP CODE

()
HOME PHONE SEX MARITAL STATUS REFERRED BY

EMPLOYED BY EMPLOYERS ADDRESS OCCUPATION BUS. PHONE

SPOUSE'S NAME EMPLOYED BY EMPLOYERS ADDRESS BUS. PHONE

NEAREST RELATIVE NOT LIVING WITH YOU RELATIONSHIP PHONE #

MEDICAL INSURANCE INFORMATION

INSURANCE HOLDERS DATE OF BIRTH INSURANCE HOLDERS SOCIAL SECURITY #

COMPANY SUBSCRIBER # POLICY # COMPANY SUBSCRIBER # POLICY #

MEDICAID NUMBER MEDICARE NUMBER

PLEASE COMPLETE THE SECTION BELOW IF SOMEONE OTHER THAN THE PATIENT IS RESPONSIBLE FOR THE BILL

NAME ADDRESS CITY STATE ZIP CODE

HOME PHONE RELATIONSHIP TO PATIENT OCCUPATION

EMPLOYER ADDRESS CITY STATE ZIP BUS. PHONE

RELEASE AND ASSIGNMENT

I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE ANY INFORMATION NEEDED TO PROCESS MY INSURANCE CLAIMS. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL AND REQUEST PAYMENT OF MEDICAL BENEFITS TO THE UNDERSIGNED PHYSICIAN.

X

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

HAS ANYONE IN YOUR IMMEDIATE FAMILY BEEN SEEN IN OUR OFFICE? YES NO

METHOD OF PAYMENT () CASH () CHECK () CHARGE

TODAY'S DATE _____

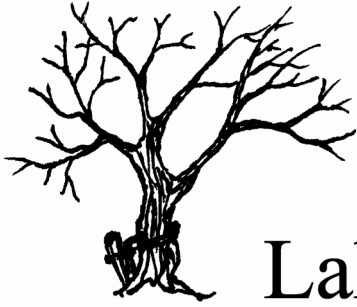
Durable Medical Equipment Policy

Lake Cook Orthopedics Associates can supply the item(s) of medical equipment that your physician has recommended at the time of service. However, you can also make arrangements to obtain this/these item(s) on your own or through your managed care program (if applicable). Your insurance plan may or may not cover the expense of this equipment. If your insurance policy does not pay for braces and other equipment, you will be responsible for payment in full. Also, if your insurance plan applies the cost of the device(s) to your deductible, you will need to pay for it personally. By accepting the item(s) of durable medical equipment, you are agreeing to pay for it.

The policy of Lake Cook Orthopedic Associates is that once durable medical equipment has left the office with a patient, it is considered used. We cannot take back used equipment, as another patient cannot be expected to use it. Therefore it is the patient's responsibility to determine whether they will accept and use the equipment BEFORE they leave the office with it. Once item(s) of durable medical equipment have left the office with a patient, it is considered used and can not be returned.

If you have questions regarding durable medical equipment, or regarding this policy, please feel free to discuss it with the front office staff at the time of your appointment.

Thank You.



FREDERICK G. LOCHER, M.D., S.C. *
 MICHAEL P. YOUNG, M.D., S.C. *
 MARK S. GROSS, M.D., S.C. *
 DAVID E. NORBECK, JR., M.D., S.C. *

JACK B. PERLMUTTER, M.D., S.C. *
 CRAIG A. CUMMINS, M.D., S.C. *
 GREGORY T. BREBACH, M.D., S.C. *
 DAVID M. ANDERSON, M.D., S.C. *

In Association With:
 DAVID S. SCHNEIDER, D.O., S.C. **

Lake Cook Orthopedic Associates

27401 West Highway 22 • Suite 125 • Barrington, Illinois 60010 • (847) 381-0388 • Fax (847) 381-0811
 www.lakecookorthopedics.org

PATIENT INFORMATION AUTHORIZATION

I, _____, authorize the methods of communication of my protected health information (PHI) as indicated below. I understand that under HIPAA guidelines my patient information is held confidential unless authorized by my signature.

The following person(s) may inquire, retrieve records, prescriptions, etc. and receive messages regarding my health information:

- 1) _____ Relationship: _____ Tel: _____
- 2) _____ Relationship: _____ Tel: _____
- 3) _____ Relationship: _____ Tel: _____
- 4) _____ Relationship: _____ Tel: _____

The physicians and staff of **LAKE COOK ORTHOPEDIC ASSOCIATES** are authorized to communicate PHI such as test results, messages or appointment information. Please initial each appropriate line you wish to authorize:

- _____ Telephone Answering Machine
 _____ With person(s) listed above
 _____ Mail to: () Home () Office
 _____ Fax Machine: Fax # _____

Patient Name (Please Print): _____

Patient Signature: _____ Date: _____
 (Signature of Parent or Legal Guardian if patient is a minor)

Print Name of Parent or Legal Guardian if applicable: _____

We welcome you to Lake Cook Orthopedic Associates. It is our goal to offer you the best musculoskeletal care available. We are in the process of updating our computer software, both the practice management (scheduling and billing) as well as the electronic medical record (EMR). Beginning June 1, we will begin using the scheduling and billing portions of the new software, as well as beginning the use of electronic prescription software.

Attached you will find a questionnaire. For new patients, you will be asked to fill out a comprehensive questionnaire in addition to this form. If you have given us your medication and allergy history on the comprehensive form, please skip those sections on this form. For returning patients we are asking you to fill out a smaller questionnaire. The information required includes your choice of pharmacy, your allergies and present medications. These are necessary for the use of the electronic prescriptions. There is also a consent clause allowing us to inquire electronically about your medication history. This is required in order for us to manage your prescriptions electronically.

The information also includes some demographic information required by the federal government to meet "meaningful use" rules of the EMR program. At some point we may begin using email to communicate with our patients and are beginning to accumulate the data that will allow us to do that.

We appreciate your confidence in us, and will continue to honor your privacy in accordance with our professional standards and privacy (so called HIPAA) laws.

LAKE COOK ORTHOPEDIC ASSOCIATES

27401 West Highway 22 Suite 125
Barrington, IL 60010

First Name: _____ **MI:** ____ **Last Name:** _____

Cell Phone: _____

Patient's Email Address: _____

Emergency Contact Name: _____ **Phone:** _____

Emergency Contact Relationship: _____

Primary Race (circle one) 1) White 2) Hispanic 3) African American or Black 4) Asian
5) Native American 6) Native Hawaiian 7) Other Pacific Islander
8) Other Race 9) Unreported/Refused to Report

Ethnicity (circle one) 1) Non-Hispanic 2) Hispanic 3) Refused to Report

Language 1) English 2) Spanish 3) Other _____

Current Medications: Please include all over the counter & prescription medications.

	Name of Medication	Dose	Frequency	Reason Taken
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____
7.	_____	_____	_____	_____
8.	_____	_____	_____	_____
9.	_____	_____	_____	_____
10.	_____	_____	_____	_____

Allergies: _____

Pharmacy of Choice:

Name	Street Address	City	State	Phone Number	Mail Order?
_____	_____	_____	_____	_____	Y / N
_____	_____	_____	_____	_____	Y / N

Electronic Prescriptions:

Our electronic medical record program accesses your prescription/medication history in order for us to safely prescribe your medication. By signing this, you authorize us to do so.

Signature: _____ **Date:** _____