



Please **ONLY** mark symptoms you are experiencing for **TODAY'S** office visit.

<p><u>CARDIOVASCULAR</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Chest pain <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Palpitations <p><u>CONSTITUTIONAL</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Sweats <input type="checkbox"/> Weight gain <input type="checkbox"/> Weight loss <p><u>ENMT - Ear/Nose/Mouth/Throat</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Dizziness <input type="checkbox"/> Nose Bleeds <input type="checkbox"/> Sore throat <p><u>ENDOCRINE</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Hair Loss <input type="checkbox"/> Heat intolerance <p><u>GASTROINTESTINAL</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Abdominal swelling <input type="checkbox"/> Change in bowel habits <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Gas <input type="checkbox"/> Heartburn <input type="checkbox"/> Jaundice <input type="checkbox"/> Nausea <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Stomach cramps <input type="checkbox"/> Vomiting <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Black stool <input type="checkbox"/> Abdomen filling up with fluid 	<p><u>URINARY</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Dark urine <input type="checkbox"/> Decrease in urine flow <input type="checkbox"/> Painful urination <input type="checkbox"/> Frequent urinary infections <input type="checkbox"/> Frequent urination <input type="checkbox"/> Blood in urine <input type="checkbox"/> Impotence <input type="checkbox"/> Need to urinate at night <input type="checkbox"/> Urethral discharge or incontinence <p><u>HEMATOLOGIC/LYMPHATIC</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Bleeding gums or palpable lymph nodes <input type="checkbox"/> Easy bruising <input type="checkbox"/> Prolonged bleeding <p><u>INTEGUMENTARY (SKIN)</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Allergies <input type="checkbox"/> Dryness <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Jaundice <input type="checkbox"/> Lesions <input type="checkbox"/> Rashes <p><u>MUSCULOSKELETAL</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Arthritis <input type="checkbox"/> Back pain <input type="checkbox"/> Gout <input type="checkbox"/> Joint pain <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Stiffness 	<p><u>NEUROLOGICAL</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Frequent headaches <input type="checkbox"/> Migraine <input type="checkbox"/> Numbness or tingling <input type="checkbox"/> Seizures <input type="checkbox"/> Tremors <input type="checkbox"/> Vertigo <input type="checkbox"/> Memory loss <p><u>PSYCHIATRIC</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Difficulty sleeping <input type="checkbox"/> Hallucinations <input type="checkbox"/> Nervousness <input type="checkbox"/> Panic attacks <input type="checkbox"/> Paranoia <input type="checkbox"/> Confusion <p><u>RESPIRATORY</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Asthma <input type="checkbox"/> Cough <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Excessive sputum <input type="checkbox"/> Coughing up blood <input type="checkbox"/> Wheezing <p><input type="checkbox"/> No Symptoms</p>
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Today's Date _____

PATIENT DATA TO BE COMPLETED IN FULL

Name _____ Date of Birth _____ Social Security # _____

Marital Status Married Single Widowed Divorced Gender Male Female

Home Address _____
Street City Zip Code County

Phone Numbers Home _____ Work _____ Cell _____

Primary Phone is Home Cell Work Preferred Patient Appointment Reminder: Phone Text Email: _____

Race American Indian/Alaskan Native Asian African American/ Black Caucasian/White Other _____

Ethnicity Hispanic or Latino Non-Hispanic or Latino

Nationality: _____

Preferred Language English Polish Spanish Italian Other _____

Referred to GI Solutions by _____

EMPLOYMENT

Employer _____ Dept. | Title _____

Employer's Address _____
Street City State Zip

EMERGENCY CONTACT

Spouse, companion, relative or friend living with you _____

Name & Relationship _____ Daytime Phone _____

Nearest relative or friend not living with you _____

Name & Relationship _____ Daytime Phone _____

PREFERRED PHARMACY INFORMATION

Pharmacy Name _____ Pharmacy Phone _____
Pharmacy Address _____
Street City State Zip

I authorize GI Solutions, LLC to obtain my prescription history electronically.

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY

I certify that the above information is correct. I consent to be treated by the staff and providers of GI Solutions, LLC. I authorize payment of medical benefits to GI Solutions, LLC and authorize them to release any medical information necessary to process claims. I understand that I am responsible for co-payments, deductibles, co-insurance and non-covered services.

Patient Signature _____ Date _____

Consent for Treatment

Having voluntarily presented myself (or my dependent) _____, I acknowledge recognition of the fact that the evaluation and treatment received, advised or deemed necessary, to be the judgment of the Physician.

Patient Signature _____ Date _____



Corporate Office
1880 W. Winchester Rd
Suite 104
Libertyville, IL 60048
<http://www.gipartnersofil.com/>

Financial Policies

Thank you for choosing GI Partners of IL, LLC as your health care provider. We are committed to building a successful physician-patient relationship with you and your family. As a patient, the clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please feel free to ask any questions about our fees, policies, or patient responsibilities.

Co-pays

The patient is expected to present an insurance card at each visit. All co-payments and past due balances are **due at time of service** unless previous arrangements have been made. If you are unable to pay at the time of your visit, we reserve the right to reschedule your appointment to a later date.

Insurance Claims

Your health insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will bill your primary insurance company as a courtesy to you. To properly bill your insurance carrier, we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. It will be your responsibility to notify our office of any pertinent information changes (i.e. address, name, insurance information, etc.). Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network with your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

Referrals and Pre-Authorizations

Certain health insurance plans (HMO, POS, etc.) require that you obtain a referral or prior authorization from your Primary Care Provider (PCP) before visiting a specialist. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower or nonpayment from the insurance company, and the balance will be your responsibility. Alternative payment arrangements or rescheduling of your appointment may be necessary if not obtained.

You understand and agree that (regardless of my insurance status), that you are ultimately responsible for the balance on your account for any services rendered. You hereby authorize GI Partners to release to your insurance company, any information including diagnosis & medical records of any treatment or examination rendered. You also authorize and request your insurance company to pay GI Partners directly, the amount due after applicable payments are made by you.

Medicare Patients

We accept Medicare assignment. Therefore, you will be responsible for the balance on your account after Medicare's processing/payment. If you have supplemental insurance, we will bill the balance to that insurance company. Subsequently, any remaining balances are your responsibility.

Self-Pay Accounts

Arrangements must be made regarding payment **prior** to scheduling an appointment or procedure. Payment in full is due at time of service for office visits. Payment in full is due at least 3 days prior to a scheduled procedure.

No Show/Cancellations

We require a **24-hour notice** for any office visit cancellation. Failure to provide the **24-hour notice** may result in a \$50.00 fee being assessed. Three “no shows” may result in discharge from the practice. We require a **48-hour notice** for cancellation or rescheduling of procedures. Failure to provide the **48-hour notice** may result in a \$250.00 fee being assessed.

Statements and Collections

Patient statements are sent monthly. Payment in full is due upon receipt of statement unless other arrangements have been made. In the event the balance is still outstanding after 90 days the account may be forwarded to an outside collection agency.

Payment Methods

For your convenience we accept Cash, Check, Money Orders, Visa, Mastercard, American Express and Discover. Any checks returned for nonsufficient funds will incur a \$40.00 service charge. Another form of remittance will be required for the balance due.

Form Fees

Our practice charges for additional paperwork outside of the completion of medical records. Single page forms - \$25.00, multi-page forms -\$50.00, complex non-standard FMLA and disability forms - \$85.00

Medical Records

Copies of medical records are available upon request. The practice charges a fee for copies in accordance with the State of IL Comptroller’s Office. This fee schedule is available upon request.

I have read and understand the financial policy set forth by GI Partners. I understand that I am responsible for having the appropriate referral or authorization on file prior to my scheduled appointment. I understand that I am responsible for the “Patient Due” portion of my statement. I understand that if I do not observe this financial policy, GI Partners has the right to use other means of collection for my outstanding balance.

Patient Signature _____ **Date** _____



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www.gipartnersofil.com/

**CONSENT FOR RELEASE AND USE OF CONFIDENTIAL INFORMATION
RECEIPT OF NOTICE OF PRIVACY PRACTICES FORM**

I acknowledge receipt of the GI Partners of Illinois, LLC Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information. I understand that the physician has reserved a right to change his or her 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 on next office visit. I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

I, _____, hereby give my consent to GI Partners of Illinois, LLC for the the purpose of carrying out treatment, payment, or healthcare operations to use and disclose all information contained in the patient record of _____ (*patient's name*)

May our office leave a message on your voicemail/answering machine:

YES NO

Phone Number(s): _____

No one other than myself may have access to my medical records.

The following person(s) listed below have my permission to discuss my medical history, conditions and treatment with the physician and staff at GI Partners of Illinois, LLC. This permission remains in effect until I cancel (all or in part) by notifying GI Partners of Illinois, LLC in writing.

Name & Relationship to patient: _____

Name & Relationship to patient: _____

Name & Relationship to patient: _____

Patient Signature _____ **Date** _____