Date: ____/____/______

Name: ________________________________ DOB:____/____/______

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

CARDIOVASCULAR

- ☐ Chest pain
- ☐ Irregular heart beat
- ☐ Palpitations

CONSTITUTIONAL

- ☐ Fatigue
- ☐ Fever
- ☐ Loss of appetite
- ☐ Sweats
- ☐ Weight gain
- ☐ Weight loss

ENMT - Ear/Nose/Mouth/Throat

- ☐ Difficulty swallowing
- ☐ Dizziness
- ☐ Nose Bleeds
- ☐ Sore throat

ENDOCRINE

- ☐ Excessive thirst
- ☐ Hair Loss
- ☐ Heat intolerance

GASTROINTESTINAL

- ☐ Abdominal pain
- ☐ Abdominal swelling
- ☐ Change in bowel habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gas
- ☐ Heartburn
- ☐ Jaundice
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach cramps
- ☐ Vomiting
- ☐ Difficulty swallowing
- ☐ Black stool
- ☐ Abdomen filling up with fluid

URINARY

- ☐ Dark urine
- ☐ Decrease in urine flow
- ☐ Painful urination
- ☐ Frequent urinary infections
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Impotence
- ☐ Need to urinate at night
- ☐ Urethral discharge or incontinence

HEMATOLOGIC/LYMPHATIC

- ☐ Bleeding gums or palpable lymph nodes
- ☐ Easy bruising
- ☐ Prolonged bleeding

INTEGUMENTARY (SKIN)

- ☐ Allergies
- ☐ Dryness
- ☐ Hives
- ☐ Itching
- ☐ Jaundice
- ☐ Lesions
- ☐ Rashes

MUSCULOSKELETAL

- ☐ Arthritis
- ☐ Back pain
- ☐ Gout
- ☐ Joint pain
- ☐ Muscle weakness
- ☐ Stiffness

NEUROLOGICAL

- ☐ Dizziness
- ☐ Fainting
- ☐ Frequent headaches
- ☐ Migraine
- ☐ Numbness or tingling
- ☐ Seizures
- ☐ Tremors
- ☐ Vertigo
- ☐ Memory loss

PSYCHIATRIC

- ☐ Anxiety
- ☐ Depression
- ☐ Difficulty sleeping
- ☐ Hallucinations
- ☐ Nervousness
- ☐ Panic attacks
- ☐ Paranoia
- ☐ Confusion

RESPIRATORY

- ☐ Asthma
- ☐ Cough
- ☐ Shortness of breath
- ☐ Excessive sputum
- ☐ Coughing up blood
- ☐ Wheezing

- ☐ No Symptoms

Date: ____/____/______

Name: ___________________________________ DOB:____/____/______

Do you have the following Medical History?

- ☐ Pacemaker or Defibrillator
- ☐ A-Fib or Irregular Heartbeat
- ☐ Congestive Heart Failure
- ☐ Open Heart Surgery
- ☐ Heart Attack within 5 years
- ☐ Cardiac Valve Replacement
- ☐ Heart Stents
- ☐ Stroke
- ☐ Blood Clots
- ☐ Blood Thinners: _________________
- ☐ __________________________________
- ☐ None

Have you received the COVID vaccine?

☐ Yes ☐ No

When:___________________

Manufacturer:__________

***PLEASE PRESENT COVID VACCINE CARD TO FRONT DESK**

GI SOLUTIONS

NAME: **Date of Birth:**

Medication List:

Please list all the medications you are currently on including herbal over the counter medications.

Prescription Name	Dosage	Frequency	Purpose

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 **EMAIL ADDRESS:** ____________________________

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**_________________________________

1880 W. Winchester Rd
Suite 104
Libertyville, IL 60048
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___________________________