Poronsky Family Practice, Ltd.

REASON FOR YOUR VISIT TODAY: DATE: _____

_____

_____

CURRENT INFORMATION:

Your Name: _____ Age: _____ ☐ Male ☐ Female

Maritial Status: _____ Date of Birth: _____ Occupation: _____ Since: _____ ☐ Retired

Last Grade Finished: _____ Last Complete Exam was _____ years ago. Hobbies: _____

FAMILY HEALTH:

	Good	Poor	Died	Note Age and Cause of Death (Include Fatal Accidents and Suicides)
Grandfathers (natural, biological):	☐	☐	☐	
Grandmother's (natural, biological)	☐	☐	☐	
Father (natural , biological)	☐	☐	☐	
Mother (natural, biological)	☐	☐	☐	
Brothers/Sisters				
_____	☐	☐	☐	
_____	☐	☐	☐	
Spouse/Partner: _____	☐	☐	☐	
Children:				
_____	☐	☐	☐	
_____	☐	☐	☐	

ILLNESSES:

Check the ☐ if you've had any of the following. Check the ○ if a close blood relative/spouse has also

☐○ Alcoholism
☐○ Anemia
☐○ Asthma
☐○ Lung disease, tuberculosis
☐○ Arthritis
☐○ Mumps, measles, chicken pox
☐○ Bleeds easily
☐○ Nervous breakdown/mental illness
☐○ Blood transfusion
☐○ Cancer, tumor
☐○ Osteoporosis
☐○ Diabetes
☐○ Phlebitis
☐○ Drug abuse
☐○ Rheumatic fever
☐○ Depression
☐○ Rubella, German measles
☐○ Eczema, hives, rashes
☐○ Sexually transmitted disease
☐○ Epilepsy, seizures
☐○ Stroke
☐○ Eye problems
☐○ Suicide attempt
☐○ Glaucoma
☐○ Thyroid disease
☐○ Heart disease
☐○ Ulcer in stomach/duodeuurr
☐○ High blood pressure
☐○ HIV
☐○ Kidney/bladdler problems

Other ilnesses: _____

HOSPITALIZATIONS/SURGERY

List illnesses or opeations and approximate year. EXCLUDE NORMAL PREGNANCIES

_____ *year* _____

_____ *year* _____

MEDICINES YOU ARE TAKING

List medicines, birthcontrol pills or vitamins you take with or without a prescription:

_____

_____

MEDICINE ALLERGIES

List those that you are allergic to:

_____

_____

IMMUNIZATIONS

Check those that you have had. Note most recent year received.

☐ Mumps _____ ☐ Flu _____
☐ Polio _____ ☐ Measles _____
☐ Tetanus _____ ☐ Hepatitis _____
☐ Pneumonia ____ ☐ Rubella _____

PHYSICIAN OR NP COMPLETES THIS SECTION:

HEENT & M — Headache Vision change & last test: ____/____/____
Hearing change Sinus congestion Swallowing
Dental problem & last exam: ____/____/____
NECK — Swollen glands Stiff Pain
RESPIRATORY — Cough/Wheezingg Hay fever/Asthma Sputum
CARDIO/VASC. — Chest pain/discomfort Racing heart Swollen feel
HBP Varicose veins short of breath during sleep/exerlion Leg Pulses
BREAST — Self exam Lump Pain Discharge
Last mammogram: ____/____/____
GI — Nausea Heartburn Vomiting Pain Diarrhea Constipation
Stool black/blood Change in eating/bowel habits Bleeding
Colonoscopy/sigmoidoscopy
GU — Frequency Pain/burning Blood Stone Stresslincontineocc
Start/stop difficulty Prostate trouble Sex difficu]ty

GYN — Menarch at ____ LMP ____/____/____ Cycle ____
Flow _____ Abnormal Cramps
Contraception _____ Hyst/Menopause at ____
Abnormal bleeding/Spotting Discharge Dyspareunia
Last pap / pelvic: ____/____/____ Des Exposure
OB — Grav ____ Para ____ Pret ____ Abort ____ Live ____ C-Sec ____
MUSCULO-SKELETAL — Bone or joint Pain/swelling/deformity
SKIN — Wart or mole changes Skin problems
NEUROLOGICAL — Seizures Trembling Dizziness Memory
Lose consciousness Behavior change
MOOD — Cry often Last time felt well:
Health worries Work/family problems Considered suicide
LIFE STYLE — Smoking Exercise Cafeine Alcohol Drugs Sleep
Meals Hepatitis Sexual dissatisfaction Multiple sex partners
Homosexual encounters HIV Serology +/- Appetite Wt. change Job did/will change Marital problems/changes Seat belts
Family' member: illness, disability, social/emotional problem

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6400 W. College Drive, Suite 200 | Palos Heights, IL 60463 | *Phone:* (708) 389-5555 | *Fax:* (708) 389-8814 | www.PoronskyFamilyPractice.com

Poronsky Family Practice, Ltd.

CONSENT FOR MEDICAL TREATMENT AND RELEASE OF INFORMATION

- ☐ I hereby give Poronsky Family Practice, Ltd. my consent to perform the procedures that are necessary for medical evaluation and treatment.
- ☐ I authorize Poronsky Family Practice Ltd. to release any and all information or records concerning my mental and physical history, diagnosis, treatment, prognosis, examination, advice or care provided to me. This information includes, but is not limited to, records regarding mental health diagnosis and treatment, use of drugs, use of alcohol, Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related Complex (ARC).
- ☐ I understand that I have a right to receive a copy of this authorization upon my request.

I AUTHORIZE RELEASE TO THE FOLLOWING PERSONS:

- ☐ Only me, no one else
- ☐ All immediate family members (husband or wife, any child, either parent, any brother or sister)
- ☐ The following individuals only:

1. _____
2. _____
3. _____

print names of persons to whom we may release information

_____ _____
Signature of patient Date

_____
(If minor, parent's signature)

EMERGENCY CONTACT (*PRIMARY*)

_____ (____) _____
Name Phone (1)

(____) _____
Phone (2)

EMERGENCY CONTACT (*SECONDARY*)

_____ (____) _____
Name Phone (1)

(____) _____
Phone (2)

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT

I, _____
Patient's Printed Name

have received a copy of Poronsky Family Practice LTD's Notice of Privacy Practices.

_____ _____
Signature of Patient Date

In lieu of patient's signature, I,_____,

a staff member of ***Poronsky Family Practice LTD***, state that a good faith effort has been made to obtain the patient's acknowledgement and that the patient declined to sign. The patient has been given our current NOTICE OF PRIVACY PRACTICES.

INSURANCE ASSIGNMENT AND RELEASE

I certify that I and/or my dependents have insurance coverage with

_____

Name of Insurance Company (ies)

and assign directly to Poronsky Family Practice LTD all insurance benefits, if any, otherwise payable to for services rendered. **I understand that I am financially responsible for all charges incurred whether or not paid by insurance.** I authorize the use of my signature on all insurance submissions.

Poronsky Family Practice LTD may use my health care information and may disclose such information to the above-named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

MEDICARE/MEDIGAP AUTHORIZATION:

I request that payment of authorized Medicare benefits and, if applicable Medigap benefits, be made on my behalf to Poronsky Family Practice LTD for any services furnished to me by that provider. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

Past due accounts may be subject to a late service charge of fifteen dollars ($15.00), or maximum allowed by law if different, together with expenses incidental to collection, including reasonable attorney's fees.

_____ _____

Signature of Patient, Guardian or Personal Representative | Date

_____ _____

Print name of Patient, Guardian or Personal Representative | Relationship to Patient

PORONSKY FAMILY PRACTICE OFFICE POLICIES

Thank you for choosing Poronsky Family Practice to deliver all of your health care needs. We are committed to providing the best care possible to our patients. Our physicians, nurse practitioners and staff are committed to your continued trust and confidence.

SCHEDULING AN APPOINTMENT

When scheduling an appointment, please describe your needs to our staff so that an appropriate length of time can be reserved for you. We attempt to schedule appointments to accommodate our patients' needs.

COMPLETE PHYSICAL EXAMS

We believe that routine, annual complete physical exams with screening lab tests are very important to the maintenance of good health. Insurance benefits vary. Some policies cover "wellness" exams and others cover visits when you have a complaint. Please learn about your benefits prior to you appointment so you will know what is covered by your insurance.

KEEPING YOUR APPOINTMENT

If you are unable to keep your scheduled appointment, we ask that you call to cancel at least 24 hours before. For missed appointments not cancelled 24 hours prior to your scheduled appointment time, our policy is to charge $30.00. This charge is solely your responsibility and not your insurance company's.

Three missed appointments constitute grounds for dismissal from the practice. Additionally, if you arrive late for a scheduled appointment we reserve the right to reschedule. We do this as a courtesy to the other patients and in an effort to keep the providers running on time. Please help us serve you better by keeping scheduled appointments and arriving on time.

We strive to make every effort to see our patients at the scheduled appointment time. To facilitate this, we ask that each established patient arrive 10 minutes before their scheduled appointment to complete any appropriate documents. We also ask the following of our patients:

- Bring all medications you are actively taking or have recently taken.
- Bring blood sugar and/or blood pressure logs if applicable.

MINOR PATIENTS

All minors are required to have a parent or guardian present with them for each appointment. By law we are required to have a consent from a legal guardian to provide treatment to a minor. If a parent or guardian is unable to attend the appointment with the minor, then a signed Authorization to Treat a Minor is required prior to the appointment. If a minor comes to the office unattended and we do not have a signed and dated authorization from the parent or guardian for a specific day(s) of treatment, we will be unable to see the patient at that time, and the appointment will have to be rescheduled.

NURSE PRACTITIONERS

Nurse Practitioners (NPs) are an integral part of our office. These advanced practice nurses are educated to provide primary health care for patients and work in collaboration with our physicians. NPs care for patients with acute illnesses, manage chronic medical problems, perform routine physicals and offer health teaching. They are able to diagnose and treat, order lab work and x-rays, write prescriptions, and provide referrals to specialists when needed.

PRESCRIPTION REFILLS

Please plan ahead for prescription refills. We ask that you contact your pharmacy three to five days prior to needing a refill. If you are out of refills, the pharmacy will contact our office for approval. Please Note: We will NOT refill narcotic prescriptions outside of normal business hours or on any weekends. We will not refill prescriptions if you are outside of your recommended follow-up window. Refill requests made on Fridays may not be addressed until the following Monday

LAB AND STUDY RESULTS

If you have lab work, x-rays or any study performed, please expect to receive your results by phone within three to five business days. If you have not received either a written or verbal response within 10 days, please call the office.

CALLS TO MEDICAL PERSONNEL

Our medical staff is devoted each day to our regularly scheduled patients. Therefore, please understand when calling our providers or our medical assistants that they may not be able to immediately respond to your calls. All non-urgent calls will usually be returned by the end of the business day in which they are received.

DISMISSAL FROM THE PRACTICE

We reserve the right to dismiss any patient for reasons including but not limited to:

- Inappropriate behavior towards doctors, nurse practitioners or staff in the form of profanity, threats or inappropriate physical contact.
- Refusal to adhere to treatment plans as outlined by doctors, nurse practitioners or clinical staff.
- Abuse or misuse of prescribed medication including, but not limited to the sale, distribution or inappropriate administrator of the medication(s).
- Repeated violation of our appointment policies.
- Failure to pay your bill.
- Any reason deemed appropriate by provider.

DISMISSAL PROCESS

We will send a letter to your last known address, via certified mail, notifying you that you are being dismissed. If you have a medical emergency within 30 days of the date on this letter, we will see you on an emergent basis only. After that, you must find another doctor in a different group. We will forward a copy of your medical record to your new doctor after you let us know who it is and sign a release form.

PRIOR AUTHORIZATIONS

Prior authorizations for non-emergent services such as MRI, CT or stress test requires 72 hours notice. Once you schedule a test, you must let our office know so we can attempt prior authorization through your insurance company. If you do not give us proper notice or your insurance company denies the request and we must resubmit, you will need to reschedule the test.

OFFICE PAYMENT POLICY

The following in-office policies have been established to help us continue to provide patients with the best quality medical care. Given the constant changes in insurance company payment policies:

1. PAYMENT IS DUE AT THE TIME SERVICE IS RENDERED, unless other arrangements have been made prior to the services being rendered. This includes Copays.
    - For the patient's convenience, the office accepts cash, check, money order, Visa, Discover or MasterCard.
    - A $25 processing fee will be charged for all returned checks.
2. ANY changes to your registration information must be brought to the attention of the office BEFORE you are seen for the visit. The correct information is critical for billing purposes.
3. If you have insurance, please keep in mind that your insurance is a contract between you and your insurance company. Our office CANNOT guarantee that your carrier will pay your claim. If your claim with your insurance company is denied, the obligation for the payment is the responsibility of the patient. Our office will not enter into a dispute with the insurance carrier over a claim. We will be happy to assist whenever possible.
4. If an insurance payment is mistakenly sent to the patient instead of the office for services rendered, the patient is expected to provide payment within 10 days of receipt along with the Explanation of Medical Benefit.
5. Cancellation of an office visit MUST be made within 24 hours of a scheduled visit. Failure to do so may result in a fee, which is NOT covered by insurance.
6. In the case of financial hardship, our office will work with the patient to arrange a method of payment for services.

FINANCIAL ASSISTANCE OPTIONS

We are willing to offer payment plan options to patients with large balances or difficult financial circumstances. Please call billing at 630-522-1100 and a staff representative will be happy to review payment options that may be available to you.

Poronsky Family Practice, Ltd.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's name: _____ Date of Birth: _____

Address: _____

City/State/Zip Code: _____ / _____ / _____

Social Security Number: _____ - _____ - _____ Patient's phone number: (_____) _____

Date of Request: _____ Date Needed: _____

AUTHORIZATION

☐ **I authorize Poronsky Family Practice, LTD to release information to:**

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

(_____)_____ (_____)_____
Phone Number Fax Number

☐ **I authorize Poronsky Family Practice, LTD to obtain information from:**

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

(_____)_____ (_____)_____
Phone Number Fax Number

RECORDS REQUESTED:

I authorize the release of any and all information or records concerning my mental and physical history, diagnosis, treatment, prognosis, examination, advice or care provided to me.

This information includes but is not limited to records regarding mental health diagnosis and treatment, use of drugs, use of alcohol, acquired immune defiency syndrome (AIDS) or Aids-related-complex (ARC).

AUTHORIZATION VALID FOR: *(Check one.)*

☐ This request only.

☐ One year from the date of this authorization OR _____(Insert date.) *This authorization applies to the records of the treatment received on or prior to the date of this authorization.*

☐ This request and for medical records of any future treatment of the type described above until: _____

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a written request to the address provided at the bottom of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- Release of full records, including mental health related care, or substance abuse diagnosis and treatment information
- There may be a charge for the requested records.

NOTE: Medical records are faxed in cases of medical necessity only.

Signature of Patient or Representative _____ **Date** _____

Relationship to Patient (if requester is not the patient) _____

** Please allow at least two weeks from date received, for records to be faxed or mailed.*