GCSP
greater chicago specialty physicians
GCSPDOCS.COM

Dear Valued Patient,

Thank you for requesting an appointment in our office.

Please print and complete all the enclosed forms and bring them to your first appointment.

When you arrive at our office for your appointment, please present your completed paperwork, all insurance cards, proper identification such as a driver's license, and co-payment if required.

Please remember to bring a list of the medications you're taking and any current laboratory and procedure results. If you have an insurance plan that requires a referral, you will need to contact your primary care physician and have them forward a referral to our office. We will not be able to see you if a referral is not on file with our office by the scheduled appointment date and time.

If you had results sent over to our office from another facility, please call our office ahead of time to verify that we received everything prior to your appointment including a referral if applicable.

We ask new patients to arrive 40 minutes prior to the appointment time to allow us sufficient time for the check-in process. New patients who have pre-completed all of our paperwork ahead of time should plan to arrive 25 minutes prior to the initial appointment time and 10 minutes prior to any future follow-up appointments to allow adequate time for the check-in process.

For more information about our practice, please visit us on the web at www.GCSPDOCS.com.

If you have any questions, please call us at 630-339-5300 and thank you for choosing Greater Chicago Specialty Physicians.

Sincerely,

The Staff at Greater Chicago Specialty Physicians

PATIENT INFORMATION

Patient's full name: _____
Last First Middle Initial

Address: _____
Street Apt. No. City State Zip Code

Sex: Select Marital Status: _____ Date of Birth: _____ Age_____

Ethnicity (circle one): ☐ Non-Hispanic ☐ Hispanic ☐ Refuse to Report

Primary Race (circle one): ☐ White ☐ Hispanic ☐ African American or Black ☐ Asian ☐ Native American ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Other Race ☐ Unreported/Refuse to Report

Language (circle one): ☐ English ☐ Spanish ☐ Other_____

Email: _____ (required for Patient Portal)

Social Security #: _____ Driver's License # _____State_____

Home Telephone: _____Cell Phone: _____Fax: _____

Employer: _____Work phone_____

Employment address: _____
Street City State Zip Code

PARENT/SPOUSE:

Name: _____ Telephone:
_____

EMERGENCY CONTACT

Name: _____ Telephone: _____

Relationship:_____

Address: _____

City: _____ State: _____ Zip Code:_____ Date:_____

Patient/Guardian signature: _____

CLEAR FORM PRINT FORM

INSURANCE INFORMATION

Appointment Type:

(Circle): ■ (1) New ■ (2) Work accident ■ (3) Auto accident ■ (4) Other

Patient Name: _____
Last First Middle Initial

Responsible party: _____

Primary Insurance Company: _____Effective Date_____

Policyholder's Name: _____Birth date: _____SSN: _____

Plan Type: _____ Policy/ID No. _____Group No._____

Secondary Insurance Company: _____Effective Date_____

Policyholder's Name: _____Birth date: _____SSN: _____

Plan Type: _____ Policy/ID No. _____Group No._____

Other Insurance Information: _____

Workmen's Compensation/Personal Injury (if applicable): **Date of Injury**: _____

Attorney: _____Phone: _____Address: _____
Send Claims to: _____ Phone: _____
Contact Name (adjustor): _____ Claim #: _____
Address: _____

I hereby authorize Greater Chicago Specialty Physicians ("GCSP") to release any and all medical information to the above-named insurance carriers or their representatives (and or attorney) for the purpose of claims administration and evaluation, utilization review, and financial audit. I further authorize any person or entity responsible for the payment of my medical bill or any representative on their behalf to pay GCSP directly for charges of services rendered to me. I further understand that I am fully responsible for any financial balance resulting from insurance non-covered services, co-payments, deductibles, co-insurances and any fees/charges associated by sending my account to collections. I agree to have my records sent to any requesting legal agencies or insurance companies with the understanding that a non-designated party may inadvertently see such information.

Patient/Guardian signature: _____ Date: _____

CLEAR FORM PRINT FORM

PHYSICIAN & PHARMACY INFORMATION

REFERRING PHYSICAN

NAME: _____

ADDRESS: _____

PHONE: _____ FAX: _____

PRIMARY CARE PHYSICIAN

FULL NAME: _____

ADDRESS: _____

PHONE: _____ FAX: _____

PLEASE LIST ANY OTHER PROVIDERS

1._____ 2. _____

3._____ 4._____

PHARMACY

Name	Street Address	City	Phone	Mail Order
_____	_____	_____	_____	☐ ☐ YES / NO
_____	_____	_____	_____	☐ ☐ YES / NO

Patient/Guardian signature: _____ Date: _____

CLEAR FORM PRINT FORM

ACKNOWLEDGMENTS & AUTHORIZATIONS

_____ **(initial-required)** **Acknowledgment of Receipt of Privacy Practices Notice**

I acknowledge that I have received a copy of Greater Chicago Specialty Physicians' ("GCSP") Notice of Privacy Practices, which describes how medical information about me may be used and disclosed and how I can get access to this information.

_____ **(initial-required)** **Financial Policy:**

I acknowledge that I have read the Office and Financial Policies which is available on our website and in our office for review. I clearly understand and agree to be bound by its terms and understand that agreement with this policy is necessary for treatment at this facility. I also understand that these policies may be updated at any time without notice but can be obtained in person at our office or on our website.

_____ **(initial if authorize)** **E-HX Consent:**

YES. I authorize this practice to use and/or disclose a copy of my protected health information in the Electronic Health Information Exchange (eEHX) for the purpose of coordinating my medical care amongst my healthcare providers. I understand that including this information in eEHX enables any provider with authorized access to the eEHX to review my protected health information, including the following specially protected health information:

I acknowledge that I have been given sufficient information and have had the opportunity to have my questions answered about the Electronic Health Information Exchange (eEHX).

I understand that future withdrawal of permission to include this information in the Electronic Health Information Exchange (eEHX) will be effective except to the extent action has already been taken in reliance on this permission. When I withdraw permission my protected health information will be inactivated and the eEHX and will no longer be able to be accessed. This permission will expire if the eEHX program is discontinued.

I understand that my eligibility for treatment or any health care benefits cannot be conditioned on whether I sign this authorization form. However, to the extent I have indicated "YES" to the sharing of my protected health information, I understand that an electronic Health Information Exchange record will be available to other eEHX authorized users.

_____ **(initial if applicable)** **Authorization to Treat Minor:**

As the parent/guardian of the child/minor, I hereby give permission to the physicians and staff GCSP to treat the child/minor in the event that a medical emergency arises, and I am unable to personally consent to the treatment. I also agree to be responsible to GCSP for charges for medical services rendered.

I have read and understand the policies above and I agree to be bound by its terms.

_____ _____ _____

Signature of Patient/Representative Printed Name of Patient/Representative Date

AUTHORIZATION OF REPRESENTATIVE: I, _____, do hereby state that I am authorized to sign this permission on behalf of the patient on the following basis: Relationship to Patient _____

[A signed copy of this permission will be provided to the patient/representative]

COMMUNICATION & AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Portal: Sign up for GCSP Patient Portal? (Initial) Yes _____ No _____

By signing up for the Patient Portal, you acknowledge that you are aware that you will receive appointment reminders, lab results, and other practice related information through this and email and authorize Greater Chicago Specialty Physicians ("GCSP") to contact you via this method regarding any communication.

Communication Authorization: Please tick preferred methods of communication below

In place of or in addition to communication via the Patient Portal, please check any additional preferred method(s) for us to contact you and leave a message. If we are unable to reach you through your preferred method, we will contact you via any method necessary, except direct email, regarding medical and financial information. Please note, an appointment reminder call is a courtesy to our patients. Although we do our best to make these calls, this is not a guaranteed service.

Appointment reminders ☐**Home** ☐**Cell** ☐**Work** ☐**Portal**

Medical information including test results ☐**Home** ☐**Cell** ☐**Work** ☐**Portal**

Financial information ☐**Home** ☐ **Cell**☐**Work** ☐**Portal**

Release of medical information: I give authorization to the employees of GCSP to discuss my medical and/or financial information with the person(s) listed below. These person(s) will also serve as my emergency contact(s) unless I specify otherwise.

(Please tick)

1. _____ _____ _____ ☐**Financial** ☐**Medical**
   Name Relationship Phone

2. _____ _____ _____ ☐**Financial** ☐**Medical**
   Name Relationship Phone

3. _____ _____ _____ ☐**Financial** ☐**Medical**
   Name Relationship Phone

By signing below, I authorize GCSP to contact me and release my information by the above methods. I also understand that it is my responsibility to provide contact information where I may be reached at all times as certain tests may require urgent attention.

_____ _____ _____
Print Name Signature Date

CLEAR FORM PRINT FORM

Credit Card on File Medical Office
Effective May 1, 2019

To serve our patients is our greatest privilege and we want to continue to be able to provide the very best care to you. In order to remain in business and continue to provide excellent and personalized care to our patients, we need to make sure that patient financial responsibilities are being met in a timely manner by having a guarantee of payment in place.

- **How does the automatic credit card on file process work and when will I be charged:** You will receive a letter in the mail from your Insurance carrier that explains how much of your office visit they pay and how much you owe. This is called an Explanation of Benefits (EOB). This letter tells you exactly, according to your health insurance coverage, how much is determined to be your responsibility. We receive the same EOB and we will charge the credit card on file the exact amount as per the EOB that is stated to be "patient responsibility". Once charged, we will mail/email you a receipt of payment. *For Infusion and/or Injection services with eligible copay assist in place, your credit card will be charged accordingly. For Medicare patients with supplement insurance, your credit card or cheque on file will only be charged after your supplemental insurance processes our claim and there is still a remaining balance.*

- **What is a deductible?** An annual deductible is the dollar amount you must pay out of your own pocket during your plan year for medical expenses before your insurance begins to pay. Your insurance company must receive a claim to process in order to apply balances towards your deductible.

- **Do I need to sign a CCOF Authorization form?** Yes. The CCOF Authorization form confirms your enrollment with this program and authorizes our billing department to process patient balances accordingly.

- **When do I give you my credit card and is it stored securely?** We require you to sign the CCOF Authorization form and provide us with your credit card in person. We will swipe your credit card with an encrypted reader that will securely upload your credit card number into our third party vendor's website. Our vendor is a certified Payment Card Industry (PCI)-Data Security Standard (DSS) company that provide a robust payment card data security process, which includes prevention, detection and appropriate reaction to security incidents.

- **Can I keep my HSA card on file?** Yes, you can keep your HSA card on file, however, we may require an additional card to be kept on file should the funds in your HSA account become insufficient.

- **What if I need to dispute my bill?** We will always work with you to resolve any issues and will refund you if we have made a billing error. We will only charge the amount that we are instructed by your insurance carrier to collect from you in the same way that we normally determine how much to send you a statement for in the mail. If you disagree with how your insurance carrier processed the claim you will need to contact their customer service department directly.

- **What if I refuse to give you my credit card?** If you do not wish to keep a card on file, we will expect a cash deposit from you at the time of service. Our retainer amount is $300 and will need to be replenished when your balance reaches $100.00.

- **What if my credit card is denied?** If your credit card is denied for any reason, services at GCSP will not be rendered until an updated credit card is on file with our billing office.

Credit Card on File Authorization Form

I authorize Greater Chicago Specialty Physicians to capture my credit card/cheque information and securely store my credit card/cheque on file.

□ Cheque (voided cheque) OR Routing Number _____ Account Number_____

□ Visa □ Master Card □ Discover □ HSA

Credit Card Number (Last four digits) _____ CVV Number: _____

Expiration Date _____ / _____

Cardholder Name _____

Signature _____

Billing Address _____

City _____ State_____ Zip _____

*I, the undersigned, authorize and request Greater Chicago Specialty Physicians ("GCSP") to charge my credit card, indicated above, for **past and current balances** due for services rendered that my insurance company identifies as my financial responsibility. This will also apply to **any bank fees** **(including chargeback fees)** that apply and GCSP's **cancellation/no show policy fee**. **(NO REFUNDS WILL BE ISSUED)***

This authorization relates to all payments not covered by my insurance company for services provided to me by GCSP.

Any patient disputes relating to CCOF MUST be dealt directly with GCSP's billing department.

If the credit card is denied for any reason, I understand that services will not be rendered until an updated credit card is on file.

This authorization will remain in effect until I cancel this authorization. To cancel, I must give a 60 day notification to GCSP in writing and the account must be in good standing.

Patient Name (Print): _____

Patient Signature: _____

Date: _____ / _____ / _____

Email: _____

IF YOU DECLINE CCOF, THEN YOU MUST KEEP:

Cash Retainer ($300) on file: Yes _____

GCSP
greater chicago specialty physicians

AUTHORIZATION TO USE AND RELEASE HEALTH INFORMATION

Patient Information:

Name (First, Middle, Last): _____

Phone Number: _____ Date of Birth: _____

Address: _____

Release Information FROM (check all that apply):	**Release Information TO:**
☐ Greater Chicago Specialty Physicians' facilities OR	❑ Greater Chicago Specialty Physicians' facilities OR
☐ Specify Other Physician/Facility: _____	❑ Name of Recipient: _____
Address: _____	Address: _____
City: State: Zip: _____	City: State: Zip: _____
Phone: _____	Phone: _____
	Delivery Preference: ❑ Pickup ❑ Patient Portal ❑ Mail ❑ Fax Number _____

The purpose of this release is:

❑ **Medical** ❑ **Change of Insurance:** ❑ **Legal:** ❑ **Transfer of care:** ❑ **Moving** ❑ **Other (specify):** _____

Release the following health information within the following dates:

FROM: _____ **TO:** _____ **OR** ❑ One year

❑ Progress Notes ❑ Radiology Reports ❑ Medication History ❑ ER Reports ❑ Specialist Consultation ❑ Lab Report(s)

❑ Entire Medical Record (includes HIV/AIDS test results/Alcohol/Drug Abuse) ❑ Other Records as specified: _____

_____

I understand:

- this authorization will remain in effect for one year from the date of authorization written below. You or your Personal Representative may revoke this authorization at any time by providing written notice as specified in our Notice of Privacy Practices.
- there will be a charge for processing this request in accordance with Illinois law.
- that once this information is shared with the recipient you specified above, how that recipient further discloses it may no longer be protected under federal and state privacy regulations.
- the matters discussed on this form and release Greater Chicago Specialty Physicians, its employees, officers and directors and business associates from any legal responsibility or liability for the disclosure of the above information.

_____ _____ _____

Signature of Patient or Personal Representative Printed Name of Patient or Personal Representative Date

CLEAR FORM PRINT FORM

PAGE INTENTIONALLY LEFT BLANK

GCSP
greater chicago specialty physicians
GCSPDOCS.COM

Date: ____/____/_____

First Name _____ **Last Name** _____ **M.I.** ___ **DOB** ____/____/____

Referring Provider: _____ **PCP:** _____

Reason (s) for your visit? ❑ Pain ❑ Abnormal Test ❑ Changing Physicians ❑ Other

Please explain any of the above if needed

_____

_____

Other providers seen for this condition: ❑ None 1. _____ 2. _____

What are your current symptoms/complaints? Please include location, when it started, and how.

_____

_____

Frequency of pain: ❑ Daily ❑ Frequently ❑ Occasionally ❑ Other_____

Description of pain: ❑ Stiff ❑ Aching ❑ Dull ❑ Sharp ❑ Burning ❑ Other_____

Severity of pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (extreme pain)

Is your pain/condition: ❑ Improving ❑ Worsening ❑ Unchanged ❑ Resolved

What makes your symptoms worse? *(check all that apply)*
❑ Rest ❑ Activity ❑ Standing ❑ Sitting ❑ Bending ❑ Lifting ❑ Diet ❑ Stress
❑ Cold ❑ Heat ❑ Sunlight ❑ Lack of Sleep ❑ Temperature Changes
❑ Other(s) or further explain: _____

What makes your symptoms better? *(check all that apply)*
❑ Rest ❑ Movement ❑ Sleep ❑ Exercise ❑ Heat ❑ Cold
❑ Other(s) or further explain: _____

What other associated problems have you been having? *(check all that apply)*
❑ Swelling. Where? _____
❑ Morning Stiffness. Where? _____# of minutes to improve after activity_____
❑ Fatigue ❑ Difficulty sleeping ❑ Other(s): _____

What treatments have been tried and what percent did it help (response) from 0-100%?

1. _____ Date: _____ Response: _____ 2. _____ Date: _____ Response**:** _____

3. _____ Date: _____ Response: _____ 4. _____ Date: _____ Response**:** _____

5. _____ Date: _____ Response: _____ 6. _____ Date: _____ Response**:** _____

Medical History:

RHEUMATOLOGIC:

❑ Ankylosing Spondylitis
❑ Back/neck arthritis
❑ Gout
❑ Lupus
❑ Myositis
❑ Osteoarthritis
❑ Osteopenia
❑ Osteoporosis
❑ Psoriatic Arthritis
❑ Psoriasis
❑ Polymyalgia
❑ Rheumatoid Arthritis
❑ Sjogren's
❑ Sarcoid
❑ Vasculitis

CARDIOLOGY:

❑ High Cholesterol
❑ Heart Disease
❑ Heart Failure
❑ Heart Murmur
❑ Hypertension

GI:

❑ Liver disease/hepatitis
❑ Stomach ulcer
❑ Heartburn
❑ Colitis
❑ Irritable Bowel

ENT

❑ Sinusitis
❑ Nasal Ulcers
❑ Sleep Apnea

ENDOCRINE:

❑ Diabetes
❑ Hyperthyroid
❑ Hypothyroid

EYE:

❑ Glaucoma
❑ Cataracts
❑ Uveitis/Iritis

HEMATOLOGY:

❑ Anemia/blood disorder.
❑ Skin cancer (type)_____
❑ Cancer (type)_____

INFECTIOUS DISEASE:

❑ Shingles
❑ Tuberculosis history
❑ Infection_____

PSYCHIATRY:

❑ Depression
❑ Anxiety
❑ Bipolar

PULMLONARY:

❑ Emphysema/COPD
❑ Asthma
❑ Pneumonia
❑ Lung Disease

NEUROLOGY:

❑ Neuropathy
❑ Migraines
❑ Stroke
❑ Seizure

RENAL:

❑ Kidney disease
❑ Kidney stone

OTHER:

❑ Fibromyalgia
❑ _____
❑ _____
❑ _____

❑ Chest X-ray: Date: _____ ❑ Bone Density: Date: _____❑ Joint Imaging: Date: _____

Surgical/Hospital History: *List all operations/hospitalizations and approximate date*

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____
5. _____ Date: _____
6. _____ Date: _____
7. _____ Date: _____
8. _____ Date: _____

Social History:

1. Occupation _____❑ Working ❑ Retired ❑ Unemployed ❑ Disabled
2. Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed
3. Do you smoke or vape? ❑ Yes ❑ Never ❑ Former; # packs/day: _____; Years smoked _____
4. Do you drink alcohol? ❑Yes ❑ No; # drinks per week _____; Type_____
5. Do you use recreational drugs? ❑ Yes ❑ No; Which ones and how often? _____

Drug or other Allergies (*Please list name of medications and reactions)***:** ❑ No Known Allergies

1. _____ Reaction: _____
2. _____ Reaction: _____
3. _____ Reaction: _____
4. _____ Reaction: _____
5. _____ Reaction: _____
6. _____ Reaction: _____
7. _____ Reaction: _____
8. _____ Reaction: _____

GCSPDOCS.COM

Date: ____/____/_____

Current Medications: *(include non-prescription medications and nutritional/herbal supplements)*

Medication Name	Dose	Frequency Taken	Reason Taking	Prescribing MD

Family History: *Please mark all that apply and include pertinent family information not listed below*

Relative	Living	Age at Death	Cause of Death	Illnesses
Father				
Mother				
Brother (s)				
Sister (s)				
Maternal Grandfather				
Maternal Grandmother				
Paternal Grandfather				
Paternal Grandmother				
Children (List)				

REVIEW OF SYSTEMS (ROS)

Please mark all symptoms that you have had in the **past (Yes)** or **never (No)** or have experienced within the last 30 days **(Recent)**

CONSTITUTIONAL

weight change	O Yes	O No	O Recent
fever	O Yes	O No	O Recent
night sweats	O Yes	O No	O Recent
fatigue	O Yes	O No	O Recent
chills	O Yes	O No	O Recent

ALLERGY

sinus congestion	O Yes	O No	O Recent

DERMATOLOGY

rash	O Yes	O No	O Recent
hair loss	O Yes	O No	O Recent
dry or sensitive skin	O Yes	O No	O Recent
skin cancer	O Yes	O No	O Recent

ENT

dry mouth	O Yes	O No	O Recent
sore throat	O Yes	O No	O Recent

ENDOCRINOLOGY

excessive sweating	O Yes	O No	O Recent
diabetes	O Yes	O No	O Recent
heat intolerance	O Yes	O No	O Recent
cold intolerance	O Yes	O No	O Recent
hair changes	O Yes	O No	O Recent

HEMATOLOGY/LYMPH

Blood transfusion	O Yes	O No	O Recent
swollen glands	O Yes	O No	O Recent
easy bruising	O Yes	O No	O Recent
easy bleeding	O Yes	O No	O Recent

CARDIOLOGY

chest pain	O Yes	O No	O Recent
palpitations	O Yes	O No	O Recent
leg edema	O Yes	O No	O Recent
varicose veins	O Yes	O No	O Recent

GASTROENTEROLOGY

GERD	O Yes	O No	O Recent
nausea	O Yes	O No	O Recent
vomiting	O Yes	O No	O Recent
constipation	O Yes	O No	O Recent
diarrhea	O Yes	O No	O Recent
blood in stool	O Yes	O No	O Recent
abdominal pain	O Yes	O No	O Recent

FEMALE REPRODUCTIVE

Pregnant	O Yes	O No	O Recent
Menopause	O Yes	O No	O Recent
Sexually Transmitted Diseases	O Yes	O No	O Recent

MALE REPRODUCTIVE

Sexually Transmitted Diseases	O Yes	O No	O Recent

MUSCULOSKELETAL

joint pain	O Yes	O No	O Recent
joint swelling	O Yes	O No	O Recent
joint stiffness	O Yes	O No	O Recent
leg cramps	O Yes	O No	O Recent
myalgias	O Yes	O No	O Recent

OPHTHALMOLOGY

Dry eyes	O Yes	O No	O Recent
change in vision	O Yes	O No	O Recent
eye redness	O Yes	O No	O Recent

RESPIRATORY

hemoptysis	O Yes	O No	O Recent
shortness of breath	O Yes	O No	O Recent
cough	O Yes	O No	O Recent

NEUROLOGY

headache	O Yes	O No	O Recent
numbness	O Yes	O No	O Recent
seizures	O Yes	O No	O Recent
weakness	O Yes	O No	O Recent
dizziness	O Yes	O No	O Recent
sleep problems	O Yes	O No	O Recent

UROLOGY

dysuria	O Yes	O No	O Recent
urinary frequency	O Yes	O No	O Recent
blood in urine	O Yes	O No	O Recent
kidney stones	O Yes	O No	O Recent

PSYCHOLOGY

depression	O Yes	O No	O Recent
anxiety	O Yes	O No	O Recent

APPOINTMENT DATE: _____

PATIENT NAME: _____

PATIENT SIGNATURE: _____