3965 75th Street, Suite 103
Aurora, IL 60504
T 630.375.1625
F 630.375.1925
www.cpcsm.com

Patient Information (Please Print)	**Today's Date:**
Patient First Name:	**Patient Middle Initial:**
Patient Last Name:	**Maiden Name:**
Patient Street Address:	
City, State, Zip:	
Home Phone:	**Cellular Phone:**
Date of Birth: **Social Security Number:**	**Sex: (Circle One) Male Female**
Marital Status:(Circle One) Single Married Divorced Separated Widowed	
Race: (Circle One) Asian African American Caucasian Hispanic Native American Pacific Islander Other:	
Ethnicity: (Circle One) Hispanic or Latino Non-Hispanic or Latino	**Preferred Language**: (Circle One) English Other:
Email Address:	How did you hear about us?
May we leave test results on your answering machine? Yes No **May we relay information to anyone answering your home phone? Yes No**	
Pharmacy Name, Street and Town_____ **Mail Order Pharmacy Name & Number:** **_____**	
Emergency Contact Name: _____Relationship:_____	
Emergency Contact Phone Number(s):	
Primary Insurance Information	
Insurance Name:	Primary Card Holders Name:
Employer Name:	Date of Birth: SSN:
Secondary Insurance Information	
Insurance Name:	Primary Card Holders Name:
Employer Name:	Date of Birth: SSN:
Person Responsible for Payment (if other than Patient):	
Address: (if different than above)	

AUTHORIZATION TO RELEASE INFORMATION:

I authorize The Center for Primary Care and Sports Medicine, Lawrence T. Kacmar MD SC to release any information needed, including the diagnosis and records of any treatment/examination rendered to me or my dependents to secure payment of benefits. I understand that I am financially responsible for any balance not covered by my insurance.

SIGNATURE:_____DATE:_____

*******PAYMENT IS REQUIRED AT TIME OF SERVICE UNLESS PRIOR ARRANGMENTS HAVE BEEN MADE*******

THE CENTER FOR PRIMARY CARE
AND SPORTS MEDICINE

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Financial Policy

Thank you for entrusting The Center for Primary Care and Sports Medicine, Lawrence T. Kacmar MD SC with your health needs. We strive to provide excellence in all aspects of patient care. In order to better serve our valued patients, we would like to familiarize you with our financial policy.

PPO/HMO/POS Plans

We are contracted with multiple insurances, please verify with your insurance plan that we are contracted with your specific plan. If you have any questions, please ask our staff.

We are required under our contract with the health plans to collect any co-payments, deductibles or co-insurance. Most plans have a co-payment, which you are expected to pay at the time of service. We will bill you for any deductible or co insurance amount.

Please notify staff if you're insurance or personal information changes at any time.

Self-Pay

Unless you are a member of one of the above insurance plans or Medicare, please be prepared to pay for services at the time of service. We accept Cash, Checks, Visa, MasterCard, Discover and American Express. A 25% discount will be applied if a payment in full is paid at the time of service only.

Workman's Comp/Auto Accidents

Please be advised that if you are coming in for a workman's comp or Auto Accident injury, it is your responsibility to make sure we have the correct billing information. If we are not notified at time of service and your regular insurance is billed, we cannot change it. If your regular insurance denies it you will be required to pay the balance. If your case goes to court, you may be required to make payments until the case is settled.

******Please note with all of the above, if we are forced to send your balance to collections, you will be assessed a 25% service fee. ******

Missed Appointments

A $30.00 fee will be billed to the patient for a missed appointment if the office is not notified of need to cancel or reschedule at least 24 hours prior to your appointment.

If you have any questions regarding our policy or your account, please contact our Patient Financial Services office at (630) 375-1625. We are available Monday – Friday, between the hours of 9am and 5pm.

I have read and fully understand the above statements regarding payment policies and agree that I am responsible for any fees incurred on account for services rendered.

Patient/Legal Guardian_____**Date**_____

HEALTH HISTORY

PATIENT NAME _____ BIRTHDATE _____ TODAYS DATE _____

FAMILY HISTORY
If you or any blood relative has suffered any of the following – Please Circle and indicate whom it applies to:

Epilepsy	_____	Thyroid	_____	Osteoporosis	_____
Migraine	_____	Hay fever	_____	Arthritis	_____
Mental illness	_____	Asthma	_____	Heart Disease	_____
Glaucoma	_____	Anemia	_____	Stroke	_____
Diabetes	_____	Bleeds easily	_____	Hypertension	_____
High Cholesterol	_____	Alcoholism	_____	Hepatitis	_____
Cancer	_____	AIDS/HIV	_____	Depression	_____
Seizures	_____	Chronic fatigue	_____	Other	_____

Mother: Alive _____ Deceased _____ Brothers: # Alive _____ Deceased _____
Father: Alive _____ Deceased _____ Sisters: # Alive _____ Deceased _____

HOSPITALIZATIONS/SURGERIES (Not including pregnancies)

Year	Illness or Operations	Year	Illness or Operations

Ever had a Blood Transfusion Y N If Yes, When? _____

SOCIAL HISTORY:

Do you live: Alone_____ With Immediate Family_____ Other_____ Number of Children_____?
Do you Smoke: Y N If Yes, Cigar_____ Cigarettes_____ Other_____ How Much? _____Day/Week/Month
Do you Drink: Alcohol_____ (oz. per week) Coffee/Tea_____ (cups per day)

MEDICAL HISTORY: Mark (F) for Frequent Problems and (O) for Occasional Problems

SKIN/EXTREMITIES: Acne _____ Burning _____ Itching _____ Easy Bruising _____ Night Sweats _____
Rash/Eczema _____ Leg pain-*when walking* _____ Varicose veins/Phlebitis _____
Cold numb feet _____ Foot Pain _____ Gout _____ Back Pain _____
Tremors/Hands shaking _____ Numbness/Tingling Sensations _____

EAR/EYES: Ear Aches _____ Ringing _____ Decreased Hearing _____ Wax Build Up _____
Ear Infection _____ Dizzy Spells _____ Fainting Spells _____ Eye Pain _____
Failing Vision _____ Double or Blurred Vision _____

HEAD/NECK: Headaches _____Migraines _____ Neck Pains _____ Lump in Neck _____

NOSE/THROAT: Colds _____Sinus Problems _____ Hoarseness _____ Allergies _____ Tonsillitis _____
Nose Bleeds _____ Sore Throats _____ Difficulty Swallowing _____

HEART: Chest Pain _____ Racing Heart _____ High/Low Blood Pressure _____
Heart Murmur _____ Irregular Pulse _____ Palpitations _____ **(OVER)**
LUNGS: Coughs _____ Shortness of Breath _____ Congestion _____ Pneumonia _____

STOMACH: Indigestion/Heartburn _____ Diarrhea _____ Constipation _____ Nausea _____
Loss of Appetite _____ Abdominal Pain _____ Vomiting _____ Wt. Loss _____
Wt. Gain _____

URINARY/

GYNECOLOGICAL: MEN: Frequency _____ Incontinence _____ Decreased Stream _____
Burning/Discharge from Penis _____ Prostate Problems _____
Urine infections _____ Blood in Urine _____

WOMEN: Frequency _____ Incontinence _____ Urine infections _____
Blood in Urine _____ Burning/Discharge from Vagina _____
Menstrual Flow: Reg. Irreg. Pain/Cramps _____ Days of Flow _____
Length of Cycle _____ Pain/Bleeding during or after sex _____
Number of: Pregnancies _____ Abortions _____ Miscarriages _____
Live Births _____ Method of Birth Control _____
Date of Last Pap _____Date of Last Mammogram _____

Do you use any Assistive Devices: (Wheelchair, Cane, Oxygen): Y N If yes, explain _____

Please list **ANY KNOWN ALLERGIES** (environmental/pharmaceutical) _____
_____

Pleas list **ALL MEDICATIONS THAT YOU ARE TAKING**: _____
_____

IMMUNIZATIONS UP TO DATE FOR YOUR CHILD'S AGE: Y N Don't Know N/A (if an Adult)
****Parents Please provide a copy of immunization record****

ADULTS: Last Tetanus _____ Pneumonia Vaccine _____ Flu Vaccine _____

IF UNDER 2 YEARS OF AGE – PLEASE FILL OUT

BIRTH/NEONATAL HISTORY: Length of Labor_____ Birth Weight _____ Full Term? Y N
Complications _____
Did the baby have any problems at birth? Y N If Yes, please check: Cyanosis _____ Jaundice _____
Respiratory Distress _____ Birth Defects _____ Convulsions _____

DEVELOPMENT: When did he/she first: Demonstrate hand/eye coordination _____
Smile Socially _____ Get First Tooth _____
Sit up without help _____ Speak Words _____
Crawl _____ Hold a cup _____
Walk _____ Name Objects _____

FEEDING HISTORY:
Breastfed: Tolerance: _____ Length: _____
Formula: Type: _____ Tolerance: _____
Present Diet: _____
Vitamins: Type: _____ Amount: _____

_____
PATIENT/GUARDIAN SIGNATURE DATE

******FORM NEEDS TO BE RENEWED AND UPDATED BY PATIENT/GUARDIAN EVERY 2 YEARS******

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I. Consent for Diagnosis and Treatment

I am visiting The Center for Primary Care and Sports Medicine, Lawrence T. Kacmar MD, SC, voluntarily for the purpose of diagnosis and medical or surgical treatment. I consent to consultation by my physician, nurse practitioner and x-rays as deemed necessary. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as the result of treatment or examination while visiting The Center for Primary Care and Sports Medicine.

II. Acknowledgment of Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You may review our notice, which is displayed in the Waiting Room, posted on our website (www.cpcsm.com) and available from our Front Desk staff. As provided in our notice, the terms of this notice may change. If we change our notice, you may obtain a revised copy from our Front Desk staff.

Whom may we speak with about your health?

		Name	Phone
☐	Spouse	_____	_____
☐	Parent	_____	_____
☐	Child	_____	_____
☐	Sibling	_____	_____
☐	Other	_____	_____

III. Assignment of Benefits and Guarantee of Payment

In consideration of medical services provided to me by The Center for Primary Care and Sports Medicine, Lawrence T. Kacmar MD SC, I hereby assign The Center for Primary Care and Sports Medicine, its physicians and other professionals associated with the practice all of my rights and claims for reimbursement under any Medicare, group accident or health insurance policy for which benefits may be available for payment of the services provided. I agree to pay The Center for Primary Care and Sports Medicine and the physician and other professionals associated with the Practice the balance due of all charges not paid for the above mentioned coverage (excluding those charges not collectable pursuant to Medicare regulation). This may include cost of collection and/or reasonable attorney fees.

I have read each of the above paragraphs and fully agree to each of the statements. I acknowledge my agreement by signing below.

_____ _____
Patient Signature Date

_____ _____
Parent or Guardian (if patient is under 18 years of age) Date

THE CENTER FOR PRIMARY CARE
AND SPORTS MEDICINE
LAWRENCE T. KACMAR, MD, SC

Dr. Lawrence T. Kacmar

3965 75th Street, Suite 103 Aurora, IL 60504
Phone: 630-375-1625 Fax: 630-375-1925

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.