Lake County Neurosurgery, LLC
Lake County Neuromonitoring, LLC
Lake County Imaging, LLC
Lakeshore Physical Therapy, LLC

712 S. Milwaukee Avenue
Libertyville, Illinois 60048
P: 847.362.1848
F: 847.362.3351

Section A: Patient Information

Name: _____ Today's Date: _____

Telephone #: (H) _____ (C) _____ (W) _____

Preferred method of contact: Home ___ Cell ___ Work ___ Marital Status: Single ___ Married ___ Other ___

Home Address: _____ City/State/ZIP _____

Date of Birth: _____ Social Security #: _____ Sex: Male __ Female ___

Emergency Contact Name: _____ Phone #: _____

Referring Doctor Name: _____ Location: _____

Primary Care Doctor Name: _____ Phone #: _____

Address/City/State/ZIP: _____

Please list any additional physicians that you would like your visit notes sent to: _____

_____

I hereby consent to the treatment provide by Lake County Neurosurgery, Lake County Neuromonitoring, Lake County Imaging, Lakeshore Physical Therapy and their employees and designees. I authorize healthcare services deemed necessary or advisable by my caregivers to address my needs.

I authorize use and disclosure of my personal health information (PHI) for purposes of diagnosing and providing treatment to me, obtaining payment for my care, or for the purposes of conducting the healthcare operation of the Practice. I authorize the Practice to release information required for financial coverage for the services rendered.

I authorize payment of medical benefits directly to Lake County Neurosurgery, LLC, Lake County Neuromonitoring, LLC, Lakeshore Physical Therapy LLC and/or Lake County Imaging, LLC. The office will file all claims on my behalf to my insurance company based on information I have provided on this form. If, however, my insurance company refuses payment for any reason, I understand that I am financially responsible for any balances.

I acknowledge the "Notice of Privacy Policies" which is posted in the office and outlines my right to see and copy my record, to limit disclosure of my health information, and that I may revoke my consent for release of my records.

Acknowledged by: _____ _____
Patient Signature Date

Lake County Neurosurgery, LLC
Lake County Neuromonitoring, LLC
Lake County Imaging, LLC
Lakeshore Physical Therapy, LLC

712 S. Milwaukee Avenue
Libertyville, Illinois 60048
P: 847.362.1848
F: 847.362.3351

Circle Y (yes) or N (no) for each of the following questions and complete the indicated sections on page 2.

Are you covered under a healthcare plan? Y N ***(If yes, please complete Section B below)***

Did you sustain your injury while at work? Y N ***(If yes, please complete Section C below)***

Are your injuries from an accident that occurred outside of work? Y N ***(If yes, please complete Section D below)***

Section B: Health Insurance

Primary Insurance: _____ Policy#:_____

Group #: _____ Policy holder (If not patient):_____

Policy holder SSN:_____ DOB: _____ Relationship to Patient:_____

Secondary Insurance: _____ Policy #: _____

Group #: _____ Policy holder (if not patient): _____

Policy holder SSN:_____ DOB: _____ Relationship to Patient:_____

Section C: Work Related Injury (Worker's Compensation)

Date of Injury: _____ Employer: _____

WC Carrier: _____ Claim #: _____

Claims Address: _____ City/State/ZIP _____

Adjustor/Case Manager: _____ Phone: _____

Section D: Accident Injury (non-work related)

Date of Accident: _____ Type of Accident: Auto ___ Other ___ Claim #: _____

Auto Insurance: _____ 3rd Party Auto Insurance: _____

Attorney: _____ Phone: _____

3rd Party Attorney: _____Phone: _____

Lake County Neurosurgery, LLC
Lake County Neuromonitoring, LLC
Lake County Imaging, LLC
Lakeshore Physical Therapy, LLC

712 S. Milwaukee Avenue
Libertyville, Illinois 60048
P: 847.362.1848
F: 847.362.3351

Patient Record of Disclosures

In general, the HIPPA privacy rule gives individuals the rights to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or to elect to send correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ **Home/Cell Telephone: _____**
- ☐ **Okay to leave recorded message with detailed information**
- ☐ **Okay to leave detailed message with spouse/family member**
- ☐ **Leave message only with callback number**

☐ **Work Telephone: _____**
- ☐ **Okay to leave recorded message with detailed information**
- ☐ **Okay to leave detailed message with co-worker**
- ☐ **Leave message only with callback number**

☐ **Written Communication:**
- ☐ **Okay to mail to my home address**
- ☐ **Okay to mail to my office address**
- ☐ **Okay to fax to this number: _____**

I authorize the release of my PHI to the following individual(s) (Please do not list physicians listed on registration form):

Name	Telephone #	Relationship to Patient

Patient Signature _____

Date _____

Print Name _____

Lake County Neurosurgery, LLC
Lake County Neuromonitoring, LLC
Lake County Imaging, LLC
Lakeshore Physical Therapy, LLC

712 S. Milwaukee Avenue
Libertyville, Illinois 60048
P: 847.362.1848
F: 847.362.3351

Financial Agreement

This is an agreement between Lake County Neurosurgery LLC, a limited liability corporation, as creditor and the Patient/Debtor named on this form.

In this agreement the words "you", "your" and "yours" mean the Patient/Debtor. The word account means the account that has been established in your name to which charges are made and payments credited. The words "we", "us", and "our" refer to Lake County Neurosurgery.

By executing this agreement, you are agreeing to pay for all services that you, and/or your dependent, receive. You are ultimately responsible for payment for all services rendered.

Payment Options

Contracted Insurance (In Network): If we have an established contract with your insurance company, we will follow the terms, conditions and requirements of said contract. If you have a co-payment and/or deductible, you are required to pay those amounts when they become due. All co-payments are due at the time of your visit. There is no exception to this policy. Your insurance company makes the final determination of your eligibility and benefits. You agree to pay any and all portions of the charges for both covered and non-covered services that are not covered by your insurance.

Non-Contracted Insurance (Out of Network): Insurance is a contract between you and your insurance company; we are NOT a party to this contract. We will bill your primary and secondary, if applicable, insurance company as a courtesy to you. If you have a co-payment and/or deductible, you are required to pay those amounts, as they are your responsibility. All co-payments are due at the time of your visit. There is no exception to this policy. Your insurance company makes the final determination of your eligibility and benefits. You agree to pay any and all portions of the charges for both covered and non-covered services that are not covered by your insurance.

Medicare: We accept Medicare assignment. Medicare patients are responsible for only for the difference between the approved charges and the amount Medicare pays as well as your deductible. If you have a supplemental insurance, we will bill it directly. If you have a Medicare Advantage plan, you are required to pay your co-payment at the time of service. There is no exception to this policy.

Patients with an HMO: It is your responsibility to know and understand your HMO Medical Plan. If your HMO requires a referral and/or preauthorization, you are responsible for obtaining it and submitting it to us prior to your visit. All co-payments are due at the time of your visit. There is no exception to this policy. If no valid referral is presented prior to your visit, you agree to pay any and all portions of the charges for both covered and non-covered services that are not covered by your insurance.

Self-Pay Patients: You will be required to pay 100% of all charges at the time of your visit. Upon request, the company will be happy to provide you with a fee schedule for services provided in our offices.

Workers Compensation: We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full. We will require information regarding both your health insurance and your employer's workmen's compensation insurance. We will also verify that your employer assumes responsibility for all charges incurred. If we cannot verify responsibility or we are unable to obtain information on your employer's worker's compensation insurance, we will bill your health insurance pan. If payment is not received from these third parties within 90 days of claim submission, we have the right to bill you directly.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require written verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance company. In the absence of insurance, other financial arrangements can be arranged. Payment of the bill remains the patient's responsibility whether a lawsuit has been filed or not. Payment in full is due with 30 days of receipt of our invoice. In the case of a lawsuit, we reserve the right to place a physician's lien for payment.

For All Payment Options – We will file your charges with your primary and secondary insurance if you provide us with the proper information. You must present your insurance cards at each of your visits. If you change insurance companies, you are responsible for informing us of the change, and for presenting new insurance cards, at the time of your visit. If this information is not provided, and we submit claims to the carrier that we have on record, and the claims are denied, you will be responsible for payment for all services provided.

Lake County Neurosurgery, LLC
Lake County Neuromonitoring, LLC
Lake County Imaging, LLC
Lakeshore Physical Therapy, LLC

712 S. Milwaukee Avenue
Libertyville, Illinois 60048
P: 847.362.1848
F: 847.362.3351

Once we have received payment from your insurance company a monthly statement with the remaining charges for both covered and non-covered services will be sent to you. If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account and any payments or credits applied to your account during the month. Payment is expected in full within 30 days of receipt of the invoice. Unless a payment plan or other arrangements have been approved by the company, the balance of your statement is due and payable when the statement is issued, and is considered past due if not paid within 30 days from invoice date.

We will verify your eligibility. If your insurance company fails to provide us with the necessary information to determine your eligibility, we will notify you of this. You will have one (1) business day to contact your insurance company and provide them with the necessary releases to allow us to verify your eligibility. If we do not receive the necessary release and we cannot confirm your eligibility, payment for all services becomes your responsibility.

If your insurance company requires a referral, you are responsible for obtaining it. Failure to obtain the referral may result in a lower payment from the insurance company.

Please be aware that if payment from your insurance company or other responsible third party is not received within 90 days of claim submission, we reserve the right to bill you for all services provided.

Payment Plans: We understand that medical bills can lead to financial hardship and we will work with you to assist you in paying off your balance. We have an established payment plan program whereby payments for your outstanding charges can be divided into, no more than, twelve (12) monthly payments. A valid credit card must be presented at the time the plan is established. Your signature to our payment plan forms is required. Your signature acts as your authorization for us to charge your credit card on a monthly basis. This authorization remains in effect until the outstanding balance is zero. Your credit card statement will show the monthly payment and will serve as your receipt.

Missed Appointment Fee: Patients who do not show up for a scheduled appointment, or cancel with less than 24 hours notice will be charged a $30 fee. This fee must be paid before a new appointment is scheduled. This fee is your responsibility and is not covered by insurance.

Returned Check Fee: There is a fee for any checks returned to us by the bank. This fee can change if our bank increases its fee on returned checks.

Past Due Accounts: If your account becomes past due, we will take the necessary steps to collect this debt. If we have to refer your accounts to a collection agency, you agree to pay all of the collection costs that are incurred. If we refer collection of the balance to a lawyer, you agree to pay all lawyers' fees that we incur plus all Court costs.

Waiver of Confidentiality: You understand if your account is submitted to an attorney or collection agency, if we have to litigate in Court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Acknowledged by: _____ _____

Patient Signature Date