

Welcome To Our Office!

Name: _____ Date: _____
First Middle Last

Home Address: _____ Apt. _____

City: _____ State: _____ Zip: _____

Home: () _____ Work: () _____ Cell: () _____

SSN: _____ Birth Date: _____ Age: _____

Email Address: _____

Employer Information:

Occupation: _____

Employer: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Complete this section only if someone other than the patient is financially responsible.

Responsible Party: _____

Relationship to Patient: _____

Home Address: _____ Apt. _____

City: _____ State: _____ Zip: _____

Home: () _____ Work: () _____ Cell: () _____

SSN: _____ Birth Date: _____ Age: _____

Occupation: _____

Employer: _____ Phone: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

In case of emergency, contact: _____

Relationship to Patient: _____

Home: () _____ Work: () _____ Cell: () _____

May we contact your emergency contact for billing or insurance matters? Yes No

How did you learn about our practice? _____

If someone referred you, whom may we thank? _____

Insurance Information

Name: _____ Date: _____
First Middle Last

Privacy Options:

Do you wish phone calls to be confidential? Yes No
May we contact you at work? Yes No
Preferred method of contact: Home Work Cell Email Text
May we contact you via e-mail or text regarding your appointments? Yes No

*[Primary Insurance] * Please enter information for the Insured Party.*

Name of Insurance Company: _____
Address: _____
City: _____ State: _____ Zip: _____
Insured's Name: _____ Insured's Date of Birth: _____
Patient Relationship to the Insured Party: _____ Gender: _____
Policy ID Number: _____ Group Number: _____

*[Secondary Insurance] * Please enter information for the Insured Party.*

Name of Insurance Company: _____
Address: _____
City: _____ State: _____ Zip: _____
Insured's Name: _____ Insured's Date of Birth: _____
Patient Relationship to the Insured Party: _____ Gender: _____
Policy ID Number: _____ Group Number: _____

Please answer the questions below if you are seeking medical services for an injury:

Did your injury happen on the job? Yes No
If "Yes," on what date did the injury occur? _____ Did you
report the accident to your employer? Yes No

Our office will file insurance for all reimbursable services to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, co-pay and non-covered service amounts.

Signature: _____ Date: _____

COVID-19 Screening Questionnaire

We are asking the following questions to all practice patients to help ensure everyone's safety.

Question	Yes/No	Details
Have you or a member of your household had any of the following symptoms in the last 21 days: sore throat, cough, chills, body aches for unknown reasons, shortness of breath for unknown reasons, loss of smell, loss of taste, fever, temperature at or greater than 100 degrees Fahrenheit? (If yes, who had the symptoms, what were the symptoms, when did the symptoms start, did the symptoms stop.)		
Have you or a member of your household been tested for COVID-19? (If yes, please provide the date of test, results of the test, whether the person is currently in quarantine and the status of the person's symptoms.)		
Have you or a member of your household been advised to be tested for COVID-19 by government officials or healthcare providers? (If yes, please provide why the recommendation was made, when the recommendation was made, whether the testing occurred, when any symptoms started and stopped and the current health status of the person who was advised.)		
Were you or a member of your household advised to self-quarantine for COVID-19 by government officials or healthcare providers? (If yes, please provide why the recommendation was made, when the recommendation was made, whether the person quarantined, when any symptoms started and stopped and the current health status of the person who was advised.)		
Have you or a member of your household visited or received treatment in a hospital, nursing home, long-term care, or other health care facility in the past 30 days? (If yes, please provide the facility name, location, reason for visit/treatment and dates.)		
Have you or a member of your household traveled outside the U.S. in the past 30 days? (If yes, please provide the city, country and dates.)		
Have you or a member of your household traveled elsewhere in the U.S. in the past 21 days? (If yes, please provide the city, state and dates.)		
Have you or a member of your household traveled on a cruise ship in the last 21 days? (If yes, please provide the name of the ship, ports of call and dates.)		
Are you or a member of your household healthcare providers or emergency responders? (If yes, please provide what type of work the person does and whether the person is still working. For example, ICU nurse actively working versus a furloughed firefighter.)		
Have you or a member of your household cared for an individual who is in quarantine or is a presumptive positive or has tested positive for COVID-19? (If yes, please provide the status of the person cared for, when the care occurred, what the care was.)		
Do you have any reason to believe you or a member of your household has been exposed to or acquired COVID-19? (If yes, please provide information about the believed source of the potential exposure and any signs that the person acquired the virus.)		
To the best of your knowledge have you been in close proximity to any individual who tested positive for COVID-19? (If yes, please provide information about when the contact occurred, what the contact was, how long the people were in contact and when the diagnosis occurred.)		

I have answered the above questions truthfully and accurately.

Print Name (Patient or Person Authorized to Sign for Patient): _____

Signature: _____

Date: _____

Patient Name: _____ Date of Birth: _____ Date: _____

Medication & Allergy Chart

* Please check this box if you do not take any Prescriptions.

Prescriptions (females: please include oral contraceptives)							
Date (mm/dd/yyyy)	Name of Medicine	Dose (total milligrams)	How many times per day?	When do you take it? (Morning and night? After meals?)	Who prescribed it for you? (Physician's name)	Why do you take it?	Do you have any side effects? If yes, please describe them.

* Please check this box if you do not take any Over-the-Counter Medications.

Over-the-Counter Medications (aspirin, ibuprofen, Motrin, laxatives, antacids), Vitamins, Nutritional Supplements, Herbal Products							

* Please check this box if you do not have any Allergies.

Please List All Allergies below:	
	Reaction

GARY G. WIESMAN, MD

712 N. Dearborn Street

Chicago, IL 60654

312-796-5550

FINANCIAL POLICY

Thank you for choosing Dr. Gary Wiesman for your healthcare needs. We will always treat you with courtesy and provide you with the finest medical care. Managed care and medical billing have become increasingly complicated and misunderstandings regarding payment for medical services can often occur. We strive to maintain a cordial relationship with all of our patients; however, please understand that timely payment for our services is what allows us to continue to provide the services you have come to expect. Please read the following financial policies that include the procedures and responsibilities for payment:

- I understand that it is my responsibility to notify the office of any changes to my name, address, phone number(s), insurance policy, etc.
- All self-pay patients are required to pay in full at the time of service.
- I understand that all co-pays are due at the time of service prior to my office visit. Co-pays must be collected at the time of service in order to abide by my insurance contract.
- I understand that as a courtesy to me, the office will submit my insurance claims to my insurance provider. However, I understand that my medical insurance is a contract between my insurance company and myself and that Dr. Gary Wiesman is not a party to this contract.
- I understand that I am fully responsible for payment of any amounts for services not covered by my insurance company.
- I understand that if Dr. Gary Wiesman is a participating provider in my insurance plan, this does not guarantee that my insurance will pay for the services provided, and that failure of my insurance to pay does not relieve me of my responsibility to pay for services provided by the doctor.
- If your policy requires a referral, please have it with you when you arrive for your appointment. I understand that failure to obtain and present this referral at the time of service will result in a loss of benefits and I will be responsible for payment of all fees for the services provided.
- In addition to the principle amount owed, I agree to pay 25% of the unpaid balance as collection fees if my account is turned over to a collection agency. I further agree to pay reasonable attorney fees and court costs arising out of any litigation concerning the collection of this account.

I have read the above policies and agree to them. I authorize Dr. Gary Wiesman to provide me with medical services and to furnish information to my insurance company, worker's comp carrier or attorney concerning my treatment. I authorize payment of benefits directly to Dr. Gary Wiesman.

Please Print Patient's First and Last Name

Signature of Patient or Responsible Party

Date

GARY G. WIESMAN, MD, LTD.

712 N. Dearborn Street

Chicago, IL 60654

312-796-5550

Consent for Release and Use of Confidential Information and Receipt of Notice of Privacy Practices

I, _____, hereby give my consent to Gary G. Wiesman, MD, Ltd. _
(Name of Patient or Authorized Agent)

to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record of _____.

(Patient's Name)

I acknowledge receipt of the physician's 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 the practice website at www.wiesmannasalandsinus.com*, or by stopping by the office to pick up a copy. _

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 of my desire to do so, to the physician. 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.

At my request, I authorize Gary G. Wiesman, M.D. to disclose Protected Health Information (Medical and Billing) to:

Printed Name: _____ Relationship: _____

Printed Name: _____ Relationship: _____

Printed Name: _____ Relationship: _____

Signed: _____ Date: _____

If you are not the patient, please specify your relationship to the patient _____.

CONSENT FORM DEFINITIONS *[to be printed on reverse side of form]*

“Health care operations” refers to a large number of activities, including:

1. Conducting quality assessment and improvement activities, including outcome evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities; patient safety activities (as defined in 42 C.F.R. 3.20) population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment;
2. Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing activities;
3. Except as prohibited under 45 C.F.R. 164.502(a)(5)(i), underwriting, enrollment, premium rating, and other activities related to creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance);
4. Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;
5. Business planning and development, such as conducting cost management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies; and
6. Business management and general administrative activities including but not limited to: (a) management activities relating to HIPAA privacy rule compliance; (b) customer services, including the provision of data analyses for policy holders, plan sponsors, or other customers, provided that protected health information is not disclosed to such policy holder, plan sponsor, or customer; (c) resolution of internal grievances; (d) due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity or, following completion of the sale or transfer, will become a covered entity; and (e) creating de-identified health information, fundraising for the benefit of the covered entity, and marketing for which an individual authorization is not required.

“Payment” means the activities undertaken by the physician to obtain reimbursement for the provision of health care. These activities referred to in this definition relate to the individual to whom health care is provided and include, but are not limited to:

1. Determination of eligibility coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims;
2. Billing, claims management, collection activities, obtaining payment under a contract for reinsurance, and related health care data processing;
3. Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges;
4. Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services; and
5. Disclosure to consumer reporting agencies of any of the following information relating to reimbursement: name and address, date of birth, Social Security number, payment history, account number, and name and address of the physician.

“Treatment” means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider or another.

“Use” means the sharing, employment, application, utilization, examination, or analysis of patient information within the physician’s practice that maintains such information.

Signed: _____ Date: _____

If you are not the patient, please specify your relationship to the patient _____.