Susan M. Schneider, M.D., F.A.C.S.
301 N. Madison Street #303
Joliet, IL 60435
Phone 815-730-9900
Fax 815-730-9940

Artisan Plastic Surgery

Patients Name	**S.S. #**	**Marital Status**	**Sex**	**Birth Date**	**Age**
Street Address	**City**	**State**	**Zip Code**	**Home Phone**	**Cell Phone**
Email Address	**Were You Referred To Us? By Whom**			**Drug Allergies, If Any**	
Patients or Parent Employer	**Occupation**	**How Long Employed**		**Work Phone**	**Ext**
Employer Street Address			**City**	**State**	**Zip Code**
Spouse of Parents Name			**S.S. #**	**Birth Date**	**Work Phone**
Person Responsible For Payment	**Street Address**	**City**	**State**	**Zip Code**	**Work Phone**
Family Doctor- If you have Medicare please list your primary care physician			**Specialty Doctor (ex. Cardiology etc.)**		
Emergency Contact			**Relationships**	**Home Phone**	**Work Phone**
Pharmacy			**Pharmacy Phone**		

REFERRALS- If your insurance company requires a referral from your Primary Care Physician, it will be necessary for you to bring a referral with at each visit. Without this referral form, your insurance company will not pay for the services provided. Failure to provide us with the referral form will require that payment be made at the time of service. You will be responsible for your bill.

CO-PAYS/DEDUCTIBLE- Under Illinois Law it is required of this office that we collect all co-pays and deductibles.

The information on this form is CONFIDENTIAL and important in maintaining accurate patient record. Kindly inform us if any changes occur so that we may update your records accordingly.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the office of Dr. Susan M. Schneider, MD to release acquired Personal Data, Medical Records, and other information concerning my treatment to associated Insurance Companies, Employer Groups, Attorneys, and other Associated Physicians, as required. I assign all benefits to be paid directly to Dr. Susan M. Schneider, MD., F.A.C.S.

_____ _____

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Office Policy

Welcome
Dr. Susan M. Schneider and Staff welcome you to our practice. We look forward to seeing you for your appointment. We are committed to ensuring that your treatment is successful. Thank you for reviewing the following practice policies. Your clear understanding of these policies is important to our professional relationship.

Commercial Insurance Policy
As a courtesy to our patients, we will file claims to your insurance company on your behalf. Copayments are due at the time of service. It is also your responsibility to pay any deductibles and/ or non-covered services. You will be sent a monthly statement regarding the status of your account. If your insurance carrier does not pay your claim within 90 days of the date of service, the account balance will revert to your responsibility.

Collection Policy
Your account must be paid in full within S months from the Date of Service. Any collection and Attorney's fees that may be incurred on delinquent accounts will be added to your outstanding balance.

PPO, HMO and POS Coverage
Dr. Susan M. Schneider is currently contracted with the following carries:
MEDICARE, and BCBS (Some BCBS we are not contracted with so please contact your insurance representative). However, you are responsible for any co-payments and deductibles.

Medicare Patients
Dr. Schneider is a Medicare Provider and we do accept assignment on covered services. All Medicare patients are responsible for their 20% co-pay and annual deductible and these are due at the time of service. Please inform us of your primary care physician or referring physicians for billing purposes.

Workers' Compensation
Workers' Compensation claims are not covered by your regular insurance carrier. If you have an injury that is work-related, it is your responsibility to inform us at the time of service. We will need the appropriate billing information and authorizations will need to be obtained prior to any surgery. Failure to provide us with this information at the time of service may result in charges being reverted to your responsibility.

Usual and Customary
Occasionally, an insurance company will make a decision that a physician's fees exceed their interpretation of "usual and customary". We have taken great effort to base our feeds in accordance with our specialty and geographic range. For these reasons, we do not accept U&C reductions by insurance carriers.

Returned Checks
Any checks returned for Non-Sufficient Funds will incur a $25 Fee.

Insurance Payments to Patient
Any payments made directly to you by your insurance company must be endorsed and sent/brought into our office. Conversion of this check for your own benefit violates Illinois criminal law. Criminal penalties, up to and including imprisonment are enforced in this office if the insurance payment is not endorsed to Dr. Schneider. There will be additional fees applied and the IRS will be informed of the "extra income".

Missed Appointments
If you are unable to keep your appointment please notify our office at least 72 hours, business days, in advance. Business days are Monday - Friday 9-5pm. Failure to provide 72 hour's notice will result in a "no-show" charge.

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Cancellation of Surgery
Surgery cancellation must be done within 2 business weeks prior to surgery. Failure to give us a 2- week notice will result in 50% of the anticipated cost of your scheduled surgical procedure.

Minor Patients
All minors (less than 18 years of age) must be accompanied by their parent, grandparent, or legal guardian on their first visit. If under the age of 16, the patient may only be seen with a parent, legal guardian, or grandparent present.

_____ _____
Patient Signature Date

Disclosure of Information

In the event that Dr. Schneider's Office is unable to contact me, I give full permission to Dr. Schneider's Office to contact the individuals that I have designated below for the purpose of disclosing information pertinent to my case. This would include, but not be limited to information regarding pathology reports, scheduling, and business information. By my signature below, I agree to hold harmless and waive any liability against Dr. Schneider's Office for the disclosure of information to the individual (s) designated below:

_____ _____

_____ _____

_____ _____

_____ _____
Patient Signature Date

I do not agree to allow Dr. Schneider's Office to disclose any medical information regarding myself to any individual other than myself

_____ _____
Patient Signature Date

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Patient Agreement Form

I hereby authorize the release of pertinent medical information to my insurance carriers. I am aware that health insurance coverage varies and, while insurance carriers may use terms such as customary, reasonable, prevailing, etc. to limit their coverage, I am ultimately responsible for payment of all charges for services rendered by Dr. Schneider and any other charges incurred as a result of the treatment rendered to myself or my immediate family. If I have insurance which the doctor is contracted with, I understand that I will be responsible for any co-payments, deductibles, co-insurances, or a procedure that is not considered medically necessary by my insurance company.

I hereby understand that as part of my health care Dr. Schneider originates and maintains paper and/ or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care of treatment. I understand that this information serves as a basis for planning my care and treatment. A means of communication among the many health professionals who contribute to my care. A source of information for applying my diagnosis and surgical information to my bill, A means by which a third-party payer can verify that services billed were actually provided, and A tool for routine operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges: The right to review the notice prior to signing this consent. The right to object to the use of my health information for directory purposes, and The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

I understand that I am not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Dr. Schneider reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations.

I understand that as part of this organization's treatment payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept the terms of this consent.

_____ _____

Patient Signature Date