Suburban Plastic Surgery, S.C.

Ramasamy Kalimuthu, M.D., F.A.C.

Specializing in Plastic, Reconstructive, Cosmetic, Hand Surgery & Laser Surgery

Dear Patient,

As you may know, it has become increasingly difficult to satisfy our patients and at the same time deal with the demands of health insurance plans. More and more, due to insurance company polices, we are receiving denials for services we would like to provide. This causes both anxiety as well as disappointment for our patients.

Due to the large number of plans with different polices, it is not possible for us to know the specifics of your policy. To help provide better care for our patients and to avoid further administrative entanglements, we recommend:

Please check with your Primary Care Physician before you visit. If required please obtain a referral before your visit.

We will send a letter to your Primary Care Physician or insurance carrier outlining our recommendations. However, it is your responsibility to check with your primary physician or insurance company to obtain proper authorization for surgery. Please be sure you have the appropriate forms for the hospital and the doctor if they are required under your plan, this will prevent and delay in scheduling surgery.

It is your responsibility to provide the co-payment and other fees that your carrier does not cover, unless prior arrangements have been made.

Thank you in advance for your cooperation and understanding.

Suburban Plastic Surgery

5346 West 95th Street, Oak Lawn, Illinois 60453 708/636-8222 FAX 708/636-9798

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Oak Lawn, IL 60453
Phone: 708-636-8222 Fax: 708-636-9798

Patient Registration / Authorization / Consent Form

Please present insurance card(s) and photo I.D. for copying

Patient Information

Name______________________________ (Maiden Name) ______________________

Social Security#:____________________ Email address: ______________________

Address______________________________City______________State__________Zip________

Home Phone__________________________ Cell Phone__________________________

Birth Date____________________ Age_______ Single/ Married / Divorced / Widowed

Spouse or Nearest Relative ________________Relationship ____________Phone____________

Primary Care Physician & Phone Number: ______________________________________

Referring Physician & Phone Number: ____

Pharmacy Name____________Address________________________Phone____________

Employer______________________________ Business Phone______________________

Business Address ______________________City__________State__________Zip________

Is this a work related injury? Yes/No If yes, please specify date of injury________________

Contact Person: ________________Phone number: ______________ Claim number: __________

Is this an auto injury? Yes/No If yes, please specify date of injury__________________________

Is an attorney involved in this claim? Yes/No Name____________________ Phone Number____________

Insurance Information

Primary Insurance Name: ____________________ID#:______________Group#:____________

Subscriber Name: ______________________________ Subscriber Birth date: ______________

Relationship to Patient: __________________________ Subscriber Social Security #: ____________

Secondary Insurance Name: __________________ID#:______________Group#:____________

Subscriber Name: ______________________________ Subscriber Birth date: ______________

Relationship to Patient: __________________________ Subscriber Social Security #: ____________

Financial Responsibility, Authorization, & Consent

I hereby authorize and direct payment check (s) for benefits due for the services rendered by the above named physician(s) to be made directly to him, regardless of my insurance benefits, if any. I understand that **I am financially responsible for payment for all items and services provided to me by Suburban Plastic Surgery, regardless of insurance benefits or information provided to me by Suburban Plastic Surgery. I also understand that it is my responsibility to contact my insurance company to verify benefits and coverage.** Co-pays will be collected at the time services are rendered.

I hereby authorize the above physician(s) to release any information regarding services rendered by him and allow a photocopy of my signature to be used to file insurance.

______________________________ ______________________________

Date Signature of patient or legal Guardian/Representative

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Surgery, S.C.

HISTORY

Name: ______________________ MR: Date: ______________

Chief complaint: ______________________________________

______________________________________ Duration ______________

____

MEDICAL AND SURGICAL PROBLEM

Diabetic	Yes	No	Heart Problem	Yes	No
Hypertensive	Yes	No	Respiratory Problem	Yes	No
Thyroid Disease	Yes	No	Vascular Problem	Yes	No
Gastrointestinal	Yes	No	Cancer	Yes	No
Arthritis	Yes	No	Seizure	Yes	No

Past Surgery: ______________________________ Date: ______________

______________________________ Date: ______________

______________________________ Date: ______________

Medication: ______________________________________

____

____

Allergy: ______________________________________

No. of Pregnancies: ________ Children: ________ Height: ________ Weight: ________

PERSONAL

Smoke	No: ______	Yes: ______	Amount: ______________
Alcohol	No: ______	Yes: ______	
Recreational Drug	No: ______	Yes: ______	Type: ______________
Work Related	No: ______	Yes: ______	
Accident	No: ______	Yes: ______	

Any family history of similar problem: ______________________________________

____

Consent to Treat: I, myself (or the patient named below), hereby consent for examination and treatment as necessary and appropriate for my condition or illness by Dr. Ramasamy Kalimuthu, resident and staff under the direction of Dr. Ramasamy Kalimuthu. I also consent to taking of photographs necessary to document the status and progress. I understand that the medical record and photographs are confidential and occasionally used for scientific and educational purposes. The document may be released to insurance companies or other physicians who are involved in my health and government agencies as necessary.

I also understand that in the event of a medical emergency while in this office, 911 will be called and every effort will be made to resuscitate.

I was given information about the physician who is treating me and necessary office information. I have read and understand the above terms of treatment and confirm that I am the patient or I am authorized to sign on the patient's behalf.

Patient Name: ______________________________ Date: ______________

____

Signature of patient or legal Guardian/Representative

Reviewed

Signature: ______________________________

Dr. Ramasamy Kalimuthu

Patients Name________________________ Date:____________________

MEDICATIONS

4- way Cold Tablets		Congesprin		Madipren	
Advil		Cope		Mathotexate	
Alcohol		Coumadin		Meclomen	
Aleve		Darvon		Midol	
Alka-Seltzer		Darvon Comppound		Multivitiamins	
Amica		DayPro		Nalvadex	
Anacin		Disalcid		Naprosyn	
Anaprox		Doans Pills		Naproxen Sodium	
Ansaid		Drislan		Norgesic	
APC		Easprin		Nuprin	
Arthrotec		Ecotrin		Oruvail	
ASA		Empirin		Pamelor	
Asacol		Equagesic		Pepto-Bismol	
Ascriptin		Excedrin		Percodan	
Aspercream		Feldene		Persantine	
Aspergum		Fish Oil		Plavix	
Aspirin		Florinal		Relafen	
B C Power		Flublprofen Sodium		Robaxlsal	
Banquish		Ginger		Salsalate	
Bilberry		Ginko Blioba		Sine-Aid	
Bufferin		Goodys Headache		Sine-Off	
Cama Arthritis Pain Relief		Ibuprofen		Soma Compound	
Cayanne		Idomethacin		Synalgos - OC	
Celebrex		Indocin		Talwin	
Children's Aspirin		Kopak		Tamollfen	
Clinoril		Lodine		Ticlid	
Coricidin		Lovenox		Tolectin	
Trandate		Trental		Trillistate	
Vioxx		Vitamin C		Vitimin E	
Voltarten		Xorprin		Other	

check only if you take any of the above on a regular basis.

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I ______________________________ give my permission to Dr. Kalimuthu and his office
(print name)
staff to contact and discuss any of my medical Problems with the following people:

Name Relationship Phone Number

1. ______________________________

2. ______________________________

3. ______________________________

4. ______________________________

5. ______________________________

Password: ______________________________
(Maiden name, pets name etc… above named person will have to know)

Date: ____________________ Signature: ______________________________

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

I, ______________________, hereby give my consent to *Ramasamy Kalimuthu, M.D. and*
(Name of Patient or Authorized Agent)

Suburban Plastic Surgery, S.C. to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record of ________________________.

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 upon my next office visit or by request.

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.

Signed: ____ Date: ________________

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

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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; 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. Underwriting, premium rating, and other activities relating 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.