

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

Suburban Plastic Surgery 5346 West 95th Street

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:		
	City		
Home Phone	Cell Phone		
Birth Date	Age Single/ Married / Div	orced / Widowed	
Spouse or Nearest Relative	Relationship	Phone	
Primary Care Physician & Phone N	umber:		
	per:		
	_Address		
Employer	Business	Phone	
	City		
	No If yes, please specify date of injury		
- · · · · · · · · · · · · · · · · · · ·	Phone number:		
Is this an auto injury? Yes/No If y	es, please specify date of injury		
	n? Yes/No Name		
	Insurance Information		
Primary Insurance Name:	ID#:	Group#:	
	Subscriber Bi		
	Subscriber Soc		
			•
Secondary Insurance Name:	ID#:	Group#:	
	Subscriber Bi		
	Subscriber Social Security #:		
•		,	
	Financial Responsibility, Authorization, & C	Consent	
him, regardless of my insurance benefits, me by Suburban Plastic Surgery, regardle	eck (s) for benefits due for the services rendered by the if any. I understand that I am financially responsible for ss of insurance benefits or information provided to minsurance company to verify benefits and coverage.	or payment for all items and ne by Suburban Plastic Surg	d services provided to ery. I also understand
I hereby authorize the above physician(s) be used to file insurance.	to release any information regarding services rendered	d by him and allow a photoc	copy of my signature to
Date	 Signatur	e of patient or legal Guar	rdian/Representative



HISTORY

Name:			<u>MR:</u>	Date:	
Chief complaint:					
				_ Duration	
	MED	ICAL AND	SURGICAL PROBLEM		
Diabetic				3.7	3. 7
Hypertensive	Yes Yes	No No	Heart Problem	Yes Yes	No No
Thyroid Disease	Yes	No	Respiratory Problem Vascular Problem	Yes	No No
Gastrointestinal	Yes	No	Cancer	Yes	No
Arthritis	Yes	No	Seizure	Yes	No
Past Surgery:				Date:	
Medication:					
			•		
	-				
Allergy:					
No. of Pregnancies:	Cl	nildren:	Height:		Weight:
		<u>PI</u>	ERSONAL		
Smoke	No:		Yes: Am	ount:	
Alcohol	No:		Yes:		
Recreational Drug	No:		Yes: Typ	e:	
Work Related	No:		Yes:		
Accident	No:		Yes:		
Any family history of similar pro	blem:				
		, ,,			
my condition or illness by Dr. Ran taking of photographs necessary to and occasionally used for scientific are involved in my health and gove I also understand that in the to resuscitate.	nasamy Kalimu document the sand educational ernment agencie event of a med the physician wat I am the patien	thu, resident and status and prog I purposes. The sas necessary. lical emergencho is treating int or I am authors.	ress. I understand that the medic e document may be released to in y while in this office, 911 will me and necessary office informatorized to sign on the patient's below	r. Ramasamy Ka cal record and ph surance compani be called and e tion. I have read half.	limuthu. I also consent totographs are confidenties or other physicians wherevery effort will be made and understand the above
Signature of patient or legal Guar	rdian/Represent	tative			Reviewe
			Signature:		

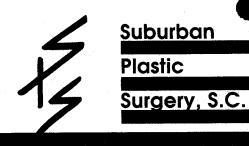
Dr. Ramasamy Kalimuthu

Patients Name	Date	
A A STATE OF STATE	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	Robaxisal	-
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	+
randate	Trental Trillistate		
/ioxx	Vitamin C	Vitimin E	
/oltarten	Xorprin	Other	

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

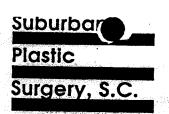


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I	give my permission to Dr. Kalimuthu and his office (print name) f to contact and discuss any of my medical Problems with the following people:			
(pringstaff to conta				: :
Name	.]	Relationship	Phone Number	<u>er</u>
1.				
				
		•	\	
4	- All State of the		·	
5				
Password: (1	Maiden name, pets name et	c above named pers	on will have to know	·)
Date:	S	ignature:		





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

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

(Name of Patient or Authorized As	geni)
Suburban Plastic Surgery, S.C. to payment, or health care operations	use or disclose, for the purpose of carrying out treatment, s, all information contained in the patient record of
I acknowledge receipt of Privacy Practice provides detailed confidential information.	the physician's Notice of Privacy Practices. The Notice of information about how the practice may use and disclose my
that are described in the Notice.	cian has reserved a right to change his or her privacy practices I also understand that a copy of any Revised Notice will be upon my next office visit or by request.
revoke this consent at any time by also understand that I will not be	ent is valid until it is revoked by me. I understand that I may giving written notice of my desire to do so, to the physician. I able to revoke this consent in cases where the physician has see my health information. Written revocation of consent must
Signed:	Date:
If you are not the patient, please sp	ecify your relationship to the patient
Partie to the control of the control	
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enter de la companya de la companya Natangan de la companya de la compa	
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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;

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;

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):

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 sa iliku wilioy 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.