

PATIENT REGISTRATION

Name			Social Security #		-	-
<i>Last</i>	<i>First</i>	<i>Middle</i>				
Address		Birth Date:	Cell phone ()		Age	
City	St	Zip	Sex: M <input type="checkbox"/> F <input type="checkbox"/>		Date of Injury	
Phone ()			Referred by:			

Accident? Yes No / Auto Work Other Employment Status: Employed Student (F/T-P/T)

Employer	Occupation	Work Phone ()	-
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Nearest Relative/Friend Not Living with You	Phone ()	-
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Spouse Name	Spouse Employed by:	Phone ()	-
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Insurance Information

Medical Ins. Co. #1

Social Sec. # Of Insured	-	-	Policy# or Group#	Relationship to patient
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Insured's Name	Authorization:
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DOB of Insured	Employer	Insurance Name
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Address	City	St	Zip	Phone ()	-
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Medical Ins. Co. #2

Social Sec. # Of Insured	-	-	Policy# or Group#	Relationship to patient
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Insured's Name	Authorization:
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DOB of Insured	Employer	Insurance Name
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Address	City	St.	Zip	Phone ()	-
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Attorney? Yes <input type="checkbox"/> No <input type="checkbox"/>	Attorney Name:	Phone ()	-
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Auto/Work Comp Ins. (Name/Address)

Adjuster Name	Phone ()	-
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I authorize treatment of the patient named above. I hereby assign all Medical Benefits to which I am entitled to **LANDMARK IMAGING SURGICAL CENTER, LLC**. I understand that I am financially responsible for all charges incurred whether or not paid by my insurance. I hereby authorize the release of any information necessary to process my claim to my insurance carrier. I permit a photocopy of this authorization to be used in place of the original.

Signature _____ Date _____



LANDMARK IMAGING SURGICAL CENTER, LLC

INSURANCE NOTICE

Thank you for choosing Landmark Imaging Surgical Center, LLC as your Surgical Center. Please be advised that Landmark Imaging Surgical Center, LLC is not contracted with any insurance company, with the exception of Medicare and United Healthcare. Our billing company, Medical Specialties Managers, Inc., will submit the claim to your insurance provider and will work with you to minimize any out-of-pocket expense that may occur.

If you have any questions regarding the billing of your procedure or your account, please contact Medical Specialties Managers, Inc., at (888) 598-8820.

Agreed and Accepted:

Patient Signature

Date

PATIENT'S RIGHTS

The rights of patient(s) include, but are not limited to:

1. Exercise these rights without regard to sex or cultural, economic, education or religious background or the source of payment for his/her care.
2. Considerate and respectful care.
3. Knowledge of the name of the physician who has primary responsibility for coordinating his/her care and the names and professional relationships of other physicians who will see him/her.
4. Receive information from his/her physician about his/her illness, course of treatment, and prospects for recovery in terms that he/she can understand.
5. Receive as much information about any proposed treatment or procedure as he/she may need in order to give informed consent or to refuse this course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in each and to know the name of the person who will carry out the procedure or treatment.
6. Participate actively in decision regarding his/her medical care. To the extent permitted by law, this includes the right to refuse treatment.
7. Full consideration of privacy concerning his/her medical care program. Care discussion, consultation, examination, and treatment are confidential and should be conducted discretely.
8. Confidential treatment of all communications and records pertaining to his/her care and his/ her stay at the center. His/her written permission shall be obtained before his/her medical records can be made available to anyone not directly concerned with his/her care.
9. Reasonable responses to any reasonable requests he/she may make for service.
10. Leave the center even against the advice of his/her physicians.
11. Reasonable continuity of care and to know in advance the time and location of appointment as well as the physician providing care.
12. Be advised if center/personal physician proposed to engage in or perform human experimentation affecting his/her care or treatment. The patient has the right to refuse to participate in such research projects.
13. Be informed by his/her physician or a delegate of his/her physician of his/her continuing health care requirements following his/her discharge from the center.
14. Examine and receive an explanation of his/her bill regardless of source of payment.
15. Know which center rules and policies apply to his/her conduct as a patient.
16. Have all patients' rights apply to the persona who may have legal responsibility to make decisions regarding medical care on behalf of the patient.
17. Designate visitors of his/her choosing. If the patient has decision-making capacity, whether or not the visitor is related by blood or marriage unless: (A) No visitors allowed; (B) The facility reasonably determines that the presence of a particular visitor to the health and safety of a patient, a member of the health facility staff, or other visitor to the health facility, or would significantly disrupt the operations of the facility; (C) the patient has indicated to the health facility that the patient no longer wants this person to visit.
18. Have the patients wishes considered for purposes of determining who may visit if the patient lacks decision-making capacity and to have the methods of that consideration disclosed in the center policy on visitation. At a minimum, the center shall include any person living in the household.
19. This section may not be constructed to prohibit a health facility from otherwise establishing reasonable restrictions upon visitation, including restriction upon the hours of visitation and the number of visitors.



PATIENT'S RESPONSIBILITIES

The responsibilities of the patient at this center are as follows:

1. To provide correct information on the patient registration form.
2. To provide the nursing staff with a complete health history, including allergies, surgical history, and current medications.
3. To follow preparation instructions and to call with any questions or problems.
4. To bring a responsible adult driver/caregiver as requested.
5. To follow the physician's post-operative instructions.

Landmark Imaging Surgical Center, LLC is accredited by the Accreditation Association for Ambulatory Health Care, Inc. Any complaints regarding services provided at Landmark Imaging Surgical Center, LLC can be directed to the AAAHC at:

**AAAHC
3201 Old Glenview Rd.
Suite 300
Wilmette, IL 66091**

By phone at (847) 853-9028 or by fax at (847) 853-9028



Physician Financial Interest and Ownership

Landmark Imaging Surgical Center, LLC is owned, in part, by the physicians of Landmark Imaging Surgical Center, LLC. The physician(s) who will be performing your procedure(s) may have financial and ownership interest. Patients have the right to be treated at another health care facility of their choice. We are making this disclosure in accordance with Federal regulations.