

How did you hear about us? _____

DATE: _____ CHART NO.: _____

P
A
T
I
E
N
T

D
A
T
A

R
E
G
I
S
T
R
A
T
I
O
N

R
E
C
O
R
D

P A T I E N T D A T A	FIRST NAME: _____ M.I. _____ LAST: _____
	ADDRESS: _____ APT _____
	CITY: _____ STATE: _____ ZIP: _____ SEX: M / F
	MARITAL STATUS: S / M / W / O EMPLOYED: Y / N OCCUPATION: _____
	EMPLOYER NAME: _____ WK #: (____) _____
	ADDRESS: _____
	CITY: _____ STATE: _____ ZIP: _____
	HM #: (____) _____ CELL #: (____) _____
	DOB: ____/____/____ AGE: _____ SSN: _____
	RELATIONSHIP TO INSURED: _____
EMAIL: _____ Can we email you through Constant Contact to let you know of Specials? Y / N	
C O N T A C T	CONTACT NAME: _____ RELATION TO PATIENT: _____
	PHONE (____) _____
R E F E R R I N G P H Y S I C I A N	REFERRING PHYSICIAN: _____ PHONE: (____) _____
	PRIMARY CARE PHYSICIAN: _____ PHONE: (____) _____
I N S U R A N C E I N F O R M A T I O N	PRIMARY PLAN NAME/ADDRESS (GUARANTOR)
	POLICY HOLDER FIRST NAME: _____ M.I. _____ LAST: _____
	DOB: ____/____/____ SSN: _____ RELATIONSHIP: _____ INS THROUGH EMPLOYER: Y / N
	POLICY HOLDER EMPLOYER: _____ WK #: (____) _____
	INSURANCE COMPANY: _____ EFFECTIVE: ____/____/____
	ADDRESS: _____
	CITY: _____ STATE: _____ ZIP: _____
	POLICY #: _____ GROUP/PLAN #: _____ CO-PAY:\$ _____
	SECONDARY PLAN NAME/ADDRESS (GUARANTOR)
	POLICY HOLDER FIRST NAME: _____ M.I. _____ LAST: _____
DOB: ____/____/____ SSN: _____ RELATIONSHIP: _____ INS THROUGH EMPLOYER: Y / N	
POLICY HOLDER EMPLOYER: _____ PHONE: (____) _____	
INSURANCE COMPANY: _____ EFFECTIVE: ____/____/____	
ADDRESS: _____	
CITY: _____ STATE: _____ ZIP: _____	
POLICY #: _____ GROUP/PLAN #: _____ CO-PAY:\$ _____	

SIGNATURE OF INSURED/GUARDIAN: _____ DATE: _____



3825 Highland Ave., Suite 5H
 Downers Grove, IL 60515
630.964.2000
www.centerderm.com

Robert V. Kolbusz, M.D.

PATIENT NAME: _____

DATE: _____

**LEGAL ASSIGNMENT OF BENEFITS AND
 RELEASE OF MEDICAL AND PLAN DOCUMENTS (SPD) SUMMARY PLAN DESCRIPTION**

I have insurance and/or employee health care benefits coverage as described on page 1 ("my health plan" or "my plan"). I assign and give directly to the Center for Dermatology and Skin Cancer, Ltd. and Robert V. Kolbusz, M.D. ("CDSC") my right to payment from the plan for medical and related services CDSC and its staff provides to me, including the right to any interest my plan may be required to pay. It is my specific wish and I hereby direct CDSC to inform my plan to make all payments for all plan benefits directly to CDSC, regardless of such provider's managed care network participation status.

I have been informed that CDSC will prepare and submit a claim for services in my name. I authorize CDSC to place my signature on all insurance and/or employee health benefits claims submissions. If requested by CDSC, I agree to sign supporting documentation as may be required, and I agree otherwise to promptly respond to CDSC's requests regarding the submission and processing of this claim. I will cooperate with CDSC and the plan in processing my claim and do all things CDSC or the plan may require in order to process and approve the claim.

I also authorize CDSC to be my designated authorized representative and to pursue all rights I may have under my plan, including to obtain a copy of documents of any sort describing coverage and to appeal any denials of payment or reimbursement to the same extent I have a right to do so. This specifically includes any right I may have to obtain information, submit any evidence, make any statements make or receive any notices and file any appeal or legal proceeding. I authorize CDSC to pursue any administrative or legal action relating to my claim against any party in my name but at CDSC's expense.

I also authorize CDSC to release all medical information necessary to process my claim to the full extent permitted by the law.

I also request CDSC notify the plan of this assignment by providing a copy of this document to the plan.

I understand that this assignment is valid for all purposes until I revoke it by providing a statement in writing to CDSC and my plan. A photocopy of this assignment is to be considered as valid as the original.

I have read and fully understand this assignment of benefits and release of medical and plan documents and have been given the right to ask any questions concerning it. I have signed this assignment as my free act without any form of either threat or promise.

SIGNATURE OF INSURED/GUARDIAN: _____

DATE: _____

HIPAA CONSENT
Consent For Release Of Information For
Treatment, Payment, and Health Care Operations

The Health Insurance Portability and Accountability Act (HIPAA) requires that The Center For Dermatology & Skin Cancer, Ltd. make available to you a description of how medical information about you may be used or disclosed and how you can get access to this information. This is called the **Notice of Privacy Practices** and copies are available on the receptionist's desk. I acknowledge that a copy of this notice has been made available to me. _____initial

The Center for Dermatology & Skin Cancer is also required to obtain a consent from you to allow us to communicate with you (or anyone you designate), your insurance company(ies), and your other health care providers. I understand that this consent is voluntary and can be revoked (in writing) at any time. I understand that the Center For Dermatology & Skin Cancer can elect not to treat me if I do not provide this consent or chose to revoke it. _____initial

I, _____, authorize Center for Dermatology & Skin Cancer to use or disclose my health information to carry out my treatment, obtain payment, and for health care operations.

.....
 In addition to the above, I authorize Center for Dermatology & Skin Cancer to notify me of all laboratory results, including, pathology results, DTM culture(s), KOH slide(s), blood work, and any other message, as follows:

Leave message(s) as follows: (check appropriate box and circle Yes, No, or NA if applies)

HOME PHONE: () _____ - _____
 ●Leave a message on my phone voice mail or answering machine? Yes No N/A
 ●Leave a message with a person who answers my home phone? Yes No N/A

CELL PHONE: () _____ - _____
 ●Leave a message on my cell phone voice mail? Yes No N/A

WORK PHONE: () _____ - _____
 ●Contact me at work and let whomever answers know who is calling if asked? Yes No N/A
 ●Leave a message on my work phone voice mail or answering machine? Yes No N/A

EMAIL: _____

HOME ADDRESS: _____

 ●Receive mail at home from Center for Dermatology other than billing statements. Yes No N/A

My medical condition and information may be discussed with the following persons:
 Name _____ Relationship _____
 Name _____ Relationship _____

 Signature of patient (or patient's representative)

 Date

 Printed name of patient (or patient's representative)

 Representative's relationship to patient



Robert V. Kolbusz, M.D.

FINANCIAL POLICY

Thank you for choosing Center for Dermatology & Skin Cancer ("CDSC") as your health care provider. We are committed to your successful treatment. The following is a statement of our Financial Policy which we require you read and sign prior to any treatment.

**Unless you are a member of an insurance plan or Medicare:
Full payment is due at the time of service. We accept cash, check, Visa, MasterCard, Discover and AMEX.**

PPO PLANS

If the doctor is contracted with your plan, the majority of members covered under this type of plan are still required to make some type of payment for service rendered to them. This may be in the form of co-payment, deductible, or co-insurance. If your plan has a co-payment, you will be expected to pay your co-payment prior to being seen by the doctor. Co-payments, deductibles, and co-insurance are requirements of your insurance plan, not CDSC, and we are required under our contract with these plans to collect these amounts from you. _____Initials

POS AND HMO PLANS

Most of these plans require that you come in to your appointment with a referral from your primary care physician ("PCP"). If you do not obtain a referral from your PCP you will be required to pay for your services in full prior to being seen. For subsequent visits, our office will fax a treatment plan and procedure recommendations to your PCP within 24 hours. The PCP will then approve the treatment plan and provide a new paper referral for your procedures/treatments/office visits. It is **YOUR RESPONSIBILITY** to call the PCP office to follow up with the status of your referral. It is **YOUR RESPONSIBILITY** to pick up the referral from your PCP's office and bring it with you for your procedures/treatments/office visits. CDSC is not responsible for facsimiles sent to our office. Without a valid referral, an office visit / procedure cannot be performed and a \$50.00 fee will be charged for the appointment time held. _____Initials

Most of the members covered under POS and HMO plans also owe co-payments, and members of POS plans may also owe deductibles and/or co-insurance. Co-payments will be collected prior to being seen by the doctor. You will be billed for co-insurance & deductible amounts. We are required under our contract with these plans to collect these amounts from you.

OUT OF NETWORK

If CDSC is not a network provider for your insurance carrier, please contact our account representatives to verify cost benefits and financial arrangement costs prior to services rendered.

BALANCES ON ACCOUNT

All previous balances are expected to be paid in full prior to services rendered. _____Initials

SURGERY/PROCEDURE APPOINTMENT GUARANTEE

A \$50.00 fee will be added to your account or charged to your credit card if you do not cancel or reschedule your appointment 48 hours prior to the appointment time. _____Initials

DIVORCE SITUATIONS

We look to the adult who has brought the child in for the appointment to be responsible for payment of services which are rendered to the child. We also expect the parents to be able to work out payment arrangements with each other and not involve our office staff in any disputes which may arise. _____Initials

SERVICE CHARGE

In the event that your insurance company has paid their portion and the balance remaining is your financial responsibility, we expect that any co-insurance, deductibles, or any other balance will be paid by you in a timely manner. Should your payment fail to reach us prior to the generation of a second billing statement to you, a service charge of \$5.00 will be added to your total balance due. This amount will be added to your balance each month until your account is paid in full. For your convenience, we do accept Visa, MasterCard, and Discover Card payments by phone. _____Initials

COLLECTIONS

Should it become necessary for Center for Dermatology & Skin Cancer to utilize the services of an outside collection agency in order to collect the amounts which are due and owed by you under the terms of your insurance coverage, you will be held liable for any and all collection agency fees and/or attorneys fees which will range from **25% to 50%** over and above the actual charges for services which were rendered to you. Information that is helpful or necessary for collection purposes will be forwarded to our collection attorney. _____Initials

I have read the Financial Policy and understand and agree to adhere to this Policy:

Signature of patient or responsible party

Date

Signature of Co-responsible party

Date

3825 Highland Avenue • Suite 5C • Downers Grove, IL 60515 • 630-964-2000 FAX 630-964-2033

(Insurance tab) 815CDSC

Our policy at Center for Dermatology requires that all patients have a guarantee of payment on file. The reason for credit card guarantee is as follows:

UNDERSTANDING CREDIT CARD GUARANTEE OF PAYMENT

How our billing process works:

1. Your insurance company is first billed.
2. After insurance payment is received you will be billed for remaining balance due at time statements are mailed out. Statements are mailed out the first of every month or sooner.
3. After you receive a statement in the mail you have 15 days from receipt of statement to make payment by any method.
4. If we do not hear from you or receive payment after 15 days, your credit card will be charged the remaining balance due.

Why us?

We had to implement credit card guarantee to keep billing costs down. The way we keep costs to a minimum is by sending you only one statement. Thereafter, we implemented a credit card guarantee system for payment on patient balances.

Examples to compare with:

When you check into a hotel, you guarantee payment for services rendered with your credit card.

Blockbuster has to guarantee movie rental against your credit card.

Car rentals have to guarantee payment and return of the car with your credit card.

Spa services guarantee payment against your credit card.

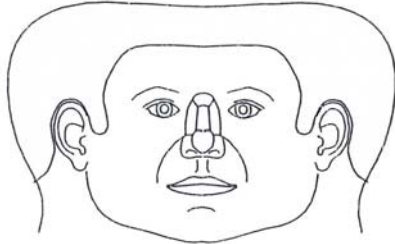
We hope this is helpful in understanding our policy.

SKIN LESION QUESTIONNAIRE

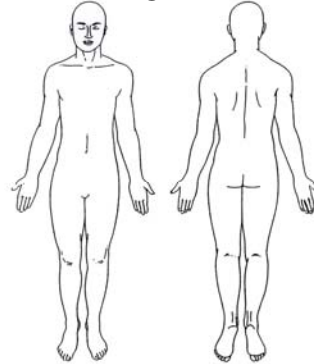
PATIENT: _____ DATE: _____

PLEASE MARK THE SITE OF YOUR LESION(S):

FACE



BODY



DURATION OF LESION(S): _____ YEARS _____ MONTHS _____ WEEKS

1. WHAT HAS BROUGHT THE LESION TO YOUR ATTENTION NOW? (CIRCLE & INITIAL)

RAPID GROWTH _____ CHANGE IN SIZE _____ CHANGE IN COLOR _____
 ITCHING _____ PAIN _____ BLEEDING _____
 BURNING _____ INTERFERES WITH VISION _____
 RUBS ON _____ INTERFERES WITH _____
 CUTS WITH SHAVING _____ TRAUMATIZED _____
 OTHER _____

2. HAS THE LESION BEEN PREVIOUSLY TREATED? YES NO

RADIATION _____ LIQUID NITROGEN THERAPY _____
 SURGICAL EXCISION _____ EFFUDEX / FLUROPLEX / ALDARA / SOLARAZE _____
 SCRAPING & BURNING _____ OTHER _____

IF SO, WHEN WAS IT TREATED? DATE: _____

**3. DO YOU HAVE A FAMILY HISTORY OF SKIN CANCER?: (CHECK ALL THAT APPLY)
 IF YES WHICH FAMILY MEMBER? _____**

BASAL CELL CARCINOMA MALIGNANT MELANOMA
 SQUAMOUS CELL CARCINOMA DYSPLASTIC NEVUS

**4. DO YOU HAVE A PERSONAL HISTORY OF SKIN CANCER? YES NO
 IF YES, WHICH TYPE?**

BASAL CELL CARCINOMA MALIGNANT MELANOMA
 SQUAMOUS CELL CARCINOMA DYSPLASTIC NEVUS

PATIENT SIGNATURE: _____

REVIEWED BY STAFF: _____

RASH QUESTIONNAIRE

PATIENT: _____ DATE: _____

AGE: _____ MALE FEMALE

DURATION OF RASH: _____ YEARS _____ MONTHS _____ DAYS

1. LOCATION(S) OF RASH SCALP FACE UPPERBODY
 ARMS LEGS HANDS OTHER _____

2. IN WHICH LOCATION DID YOUR RASH BEGIN: _____
 AND THEN WHERE DID IT SPREAD TO: _____

3. HAVE YOU EVER HAD A SIMILIR RASH? YES NO

4. IS THE RASH: CONSTANT COMES AND GOES

5. DOES YOUR RASH ITCH? YES NO

6. DO OTHER MEMBERS OF YOUR FAMILY ITCH? YES NO

7. ARE YOU CURRENTLY TREATING OR RECEIVED PAST TREATMENT? YES NO
PRODUCT NAME DATES TREATED

8. FAMILY HISTORY
 DO YOU OR YOUR FAMILY MEMBER(S) HAVE A HISTORY OF:

CIRCLE ONE (S)	CIRCLE M FOR YOURSELF OR LIST FAMILY MEMBER(S)
PSORIASIS <input type="checkbox"/> YES <input type="checkbox"/> NO	_____
ECZEMA <input type="checkbox"/> YES <input type="checkbox"/> NO	_____
XEROSIS <input type="checkbox"/> YES <input type="checkbox"/> NO	_____
ASTHMA <input type="checkbox"/> YES <input type="checkbox"/> NO	_____
ALLERGIES <input type="checkbox"/> YES <input type="checkbox"/> NO	_____
HAY FEVER <input type="checkbox"/> YES <input type="checkbox"/> NO	_____
OTHER SKIN CONDITIONS <input type="checkbox"/> YES <input type="checkbox"/> NO	_____

9. SKIN CARE HISTORY
 HOW OFTEN DO YOU BATHE? _____

WHICH BRANDS OF SOAP(S) DO YOU USE? _____

DO YOU BATHE WITH WARM OR HOT WATER? _____

DO YOU USE MOISTURIZERS ROUTINELY? YES NO

WHICH BRANDS? _____

SIGNATURE: _____

ACNE QUESTIONNAIRE

PATIENT: _____ DATE: _____

AGE: _____ MALE FEMALE

DURATION OF ACNE: _____ YEARS _____ MONTHS

AREAS AFFECTED BY ACNE: FACE CHEST BACK (CIRCLE ALL THAT APPLY)

1. Today does your acne look: GOOD BAD EXCELLENT (CIRCLE ONE)
2. Are you currently treating your acne with over-the-counter products? Yes / No (circle one)
If yes, which product(s)?

3. Have you used any of the following medications?

ACCUTANE Yes No Duration of treatment: _____ months
Dosage per day: 20MG 40MG 60MG 80MG (circle one)

Dates treated: _____

ORAL ANTIBIOTICS: Yes No TOPICAL PRODUCTS: (circle one)

	Dosage	Treatment Dates		
Doryx	_____	_____	Cleocin SOL GEL LOTION PLEDGETTES	
Dynacin	_____	_____	Clindagel CLIDAMAX LOTION GEL	
Adoxa	_____	_____	Duac Gel BENZACLIN OTHER _____	
Ampicillin	_____	_____	Retin A CR _____%	Retin A Micro _____
Doxycycline	_____	_____	Tazorac CR _____%	Tazorac Gel _____%
Erythromycin	_____	_____	Differin Gel	Differin Cream
Minocin	_____	_____	Benzac AC 10% Wash _____	Brevoxyl CR Wash
Other	_____	_____	Plexion Cloths _____	Plexion Cleanser _____

WARNING TO FEMALE PATIENTS: Many acne medications CANNOT be used in women during pregnancy and breastfeeding, nor if you are planning pregnancy in the near future.

Are you currently:
Pregnant Yes No Planning Pregnancy Yes No
Breastfeeding Yes No Sexually Active Yes No

If you are sexually active, do you use birth control?

Birth Control Pill	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Depo-Provera	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Male Vasectomy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hysterectomy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Rhythm Method	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Condom	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Spermicide	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diaphram	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Intrauterine Device	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tubal Ligation	<input type="checkbox"/> Yes	<input type="checkbox"/> No

SIGNATURE: _____

PARENTAL CONSENT TO RECEIVE MEDICAL TREATMENT

I, _____, (*representative*)

authorize

_____, (*patient*)
(*circle one:* son daughter other [specify] _____)

to receive medical treatment during an initial office visit by Dr. Robert V. Kolbusz and/or Dr. Kolbusz's Physician Assistant and any follow-up office visits.

Signature of Representative

Date

Representative's relationship to patient

HMO INSURANCE INFORMATION (HEALTH MAINTENANCE ORGANIZATION)

- **What does HMO mean?**

When you select an HMO (Health Maintenance Organization) insurance plan, you have contracted with your insurance company for all of your medical care to first be provided by your primary care physician (PCP). You have been referred to a specialist because your PCP has determined that your condition needs consultation in an area of special expertise and you are provided with a referral form.

- **Referrals for office visits**

Your referral form is valid for a certain number of days which will vary with insurance companies. It is the **patient's responsibility** to make sure that the referral is valid within the time frame allotted by the insurance company. Also, it is the **patient's responsibility** to obtain the referral form from their PCP.

Consultation can only be conducted for the services listed on your referral form.

If you have any questions regarding whether your referral is valid or if you need a new referral prior to your visit, please contact our office.

- **Scheduling procedures**

Once your consultation has been performed and it has been determined that a procedure needs to be done, you will schedule a procedure date. Unfortunately, HMO's will not allow procedures to be performed at the initial consultation. ***If the procedure was performed on the day of the initial consultation, the patient would be directly responsible for the charges.***

Our office will fax a treatment plan and procedure recommendations to your PCP within 24 hours.

The PCP will then approve the treatment plan and provide a new paper referral specifically for your procedure.

It is your responsibility to call the PCP office to follow up with the status of your referral.

Our office will assist you in the referral process for the procedure and notify you when the referral has been authorized.

It is your responsibility to pick up the referral from your PCP's office and bring it with you for your procedure / treatment / or office visit. ***Without a valid referral an office visit / procedure cannot be performed and a \$50.00 fee will be charged for the appointment time held.***

HMO/HPH REFERRAL PROCESS

1. Our office will fax a treatment plan and procedure recommendations to your Primary Care Physician (“PCP”) within 24 hours.
2. The PCP will then approve the treatment plan and provide a new paper referral specifically for your procedure.
3. It is **YOUR RESPONSIBILITY** to call the PCP office to follow up with the status of your referral.
4. It is **YOUR RESPONSIBILITY** to pick up the referral from your PCP’s office and bring it with you for your procedure/treatment/or office visit.
5. HPH does not forward patient copy of their referral. HPH faxes reply to referral request to both the PCP and to the specialist.
6. Without a valid referral an office visit / procedure cannot be performed and a \$50.00 fee will be charged for the appointment time held.
7. For further questions please contact our referral specialist, Linda at:

630-964-2000 X 304

630-786-5021/fax

Imirabella.cdsc@sbcglobal.net

PPO INSURANCE INFORMATION

- **What does PPO insurance mean?**

The doctor has contracted with your insurance company to provide services at a fixed and discounted rate. **All fee structures and codes have been previously negotiated and agreed to by the physician and insurance carrier.** The patient is responsible by contract for all deductibles and co-payment amounts.

- **Deductibles and Co-payments**

Since there are now hundreds of different insurance plans and many different policies within an insurance plan, it is impossible to know at the time of service what each individual's deductible responsibilities are. Deductibles may vary from zero to as much as \$1000.00 or more depending on the policy that you have chosen.

- **Guarantee of Deductibles and Co-payments**

To continue to provide quality service at preferred discounted rates and to keep billing costs under control, it has become necessary to require guaranteed payment of deductibles, co-insurances and co-payments prior to services performed.

For your convenience, we have developed with Visa, Master Card, Discover and American Express companies direct credit card billing, after your insurance company has paid all its benefits in total.

For example: For a charge of \$100.00, your insurance carrier paid \$80.00 and your deductible or co-insurance is \$20.00, the \$20.00 will be billed to your credit card of choice after payment has been received by your insurance carrier.

This system will help to control billing costs as well as create an easy system for payment of your medical charge. **If no deductible or coinsurance is required, nothing will be billed to your card.**

Thank you for your cooperation. If you have any questions, please feel free to speak with a business representative.

MEDICARE ASSIGNMENT

**DR. KOLBUSZ AND THE CENTER FOR DERMATOLOGY & SKIN CANCER
HAVE AGREED TO ACCEPT MEDICARE ASSIGNMENT**

- Our office bills at Medicare approved rates.
- Medicare pays the doctor 80% of the “approved amount”.
- The patient is responsible to pay 20% of the “approved amount” and any unmet deductible to the doctor.

EXAMPLE:

Medicare APPROVED.....	\$100.00
Medicare PAYS 80%.....	<u>\$80.00</u>
Patient PAYS 20%.....	\$20.00

Please contact our billing office with further questions.

PATIENT AUTHORIZATION FOR RELEASE OF CONFIDENTIAL HEALTH INFORMATION

I, _____, hereby authorize **Dr. Robert V. Kolbusz** to release to:

(Name of Health Care Facility, Physician, Agency, etc.)

(Street Address, City, State and Zip Code)

the following information contained in the patient record of:

Patient Name: _____
Birthdate: _____
Address: _____

- The entire medical record, excluding mental health treatment, alcoholism treatment, drug abuse treatment, and HIV/acquired immune deficiency syndrome (AIDS) records
- HIV/Acquired Immune Deficiency Syndrome (AIDS) Records
- Laboratory Reports
- X-ray Reports
- Operative Notes
- Other: _____

The above information for the following period of time shall be released:

From: _____ to _____
(Date) (Date)

The purpose(s) of the authorization is/are: _____

I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above-described information, I understand that it will not be disclosed, except as provided by law.

I understand that the practice may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.

I understand that Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law.

I understand that this authorization is valid until it expires, unless revoked before that.

I understand that I may revoke this authorization at any time by giving written notice to the physician of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclose my health information. Written revocation must be sent to the physician's office. Absent such written revocation, this Authorization for Release of Confidential Health Information will terminate on _____ (date).

Signed: _____

Date: _____

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

Medical Records Copying Fees

If a patient or doctor requests medical records or slide copies for their own use (own use defined as choosing to go to another doctor*, patient personal file copy, for an attorney or for any other reason) then under 735 ILCS 5/8-2006:

Supplies & labor charge	\$24.44
Copy pages 1-25	\$0.92 (per pg.)
Copy pages 25-50	\$0.61 (per pg.)
Copy pages in excess of 50	\$0.31 (per pg.)
Copies made from microfiche/film	\$1.53 (per pg.)
Color copy pages	\$2.00 (per pg.)
Slides	\$25.00 (per slide)

E.g., patient chart consists of 26 pages of documents for copying:

\$24.44 supplies & labor
\$23.00 pages 1-25
<u> \$.61</u> page 26
\$48.05 TOTAL

***EXCEPTION:** If Dr. Kolbusz is referring the patient to another doctor, there is no charge.



Robert V. Kolbusz, M.D.

PATIENT AUTHORIZATION FOR RELEASE OF CONFIDENTIAL HEALTH INFORMATION DIRECTLY TO DR. ROBERT V. KOLBUSZ

I, _____, hereby authorize _____ to release to:

Dr. Robert V. Kolbusz
3825 Highland Ave., Suite 5C
Downers Grove, IL 60515
(630) 964-2000

(Name of Health Care Facility, Physician, Agency, etc.)

the following information contained in the patient record of:

Patient Name: _____
Birthdate: _____
Address: _____

- checkbox The entire medical record, excluding mental health treatment, alcoholism treatment, drug abuse treatment, and HIV/acquired immune deficiency syndrome (AIDS) records
checkbox HIV/Acquired Immune Deficiency Syndrome (AIDS) Records
checkbox Laboratory Reports
checkbox X-ray Reports
checkbox Operative Notes
checkbox Other: _____

The above information for the following period of time shall be released:

From: _____ to _____
(Date) (Date)

The purpose(s) of the authorization is/are: _____

I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above-described information, I understand that it will not be disclosed, except as provided by law.

I understand that the practice may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.

I understand that Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law.

I understand that this authorization is valid until it expires, unless revoked before that.

I understand that I may revoke this authorization at any time by giving written notice to the physician of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclose my health information. Written revocation must be sent to the physician's office. Absent such written revocation, this Authorization for Release of Confidential Health Information will terminate on _____ (date).

Signed: _____

Date: _____

PLEASE SEND ALL COPIES OF MEDICAL RECORDS TO DR. KOLBUSZ'S OFFICE ADDRESS ABOVE

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