COMPREHENSIVE GASTROINTESTINAL HEALTH
Health History Form

NAME: _____ DATE: _____

BIRTHDATE: _____ AGE: _____ REFERRED BY: _____

HEIGHT: _____ WEIGHT: _____ PRIMARY CARE DOCTOR: _____

PHARMACY (name, location, phone/fax number): _____

GENDER IDENTITY

☐ Female ☐ Male ☐ Non-binary ☐ Other ☐ Trans (male to female) ☐ Trans (female to male)

SEX ASSIGNED AT BIRTH

☐ Female ☐ Male ☐ Uncertain

ALLERGIES

☐ NONE ☐ Codeine ☐ Iodine dye ☐ Morphine ☐ Propofol ☐ Surgical tape
☐ Aspirin ☐ Demerol ☐ Latex ☐ Penicillin ☐ Sulfa ☐ Versed

Other: _____

Any prior difficulties with sedation or anesthesia (nausea/vomiting, high tolerance, other)? ☐ Yes ☐ No

REASON FOR YOUR VISIT TO THE OFFICE

☐ Heartburn
☐ Excessive belching
☐ Upper abdominal pain
☐ Diarrhea
☐ Rectal bleeding
☐ Decreased appetite
☐ Screening colonoscopy
☐ Difficulty swallowing
☐ Chest pain
☐ Lower abdominal pain
☐ Constipation
☐ Black stools
☐ Weight loss
☐ Personal history of colon polyps/cancer
☐ Painful swallowing
☐ Nausea
☐ Bloating
☐ Narrowed stools
☐ Hemoccult + stools
☐ Abnormal liver tests
☐ Family history of colon polyps/cancer
☐ Regurgitation
☐ Vomiting
☐ Gas/flatulence
☐ Rectal pain/itch
☐ Anemia
☐ Jaundice
☐ Abnormal ultrasound or CAT scan

Other: _____

Have you had any of the following done to evaluate for the cause of your symptoms?

☐ Laboratory tests or blood work
☐ Radiology imaging (x-rays, ultrasounds, CAT scans, MRIs, barium studies)
☐ Endoscopies (upper GI scope/EGD, ERCP, colonoscopy)
☐ Emergency room visits

*** If possible, we would greatly appreciate it if you could please bring any of these relevant records with you or have them faxed to our office in advance of your visit 224.407.2255.*

What medications, supplements, or dietary interventions have you tried to treat your symptoms with (non-prescription and prescription)?

_____

_____

PAST MEDICAL ILLNESSES

Gastrointestinal

- ☐ Heartburn/GERD
- ☐ Hiatal hernia
- ☐ Gastritis
- ☐ H. pylori
- ☐ Ulcer
- ☐ Celiac disease
- ☐ Bowel obstruction
- ☐ Gallstones
- ☐ Pancreatitis
- ☐ Irritable bowel (IBS)
- ☐ Lactose intolerance
- ☐ Diverticulosis
- ☐ Diverticulitis
- ☐ Ulcerative colitis
- ☐ Crohn's disease
- ☐ Colon polyp
- ☐ Colon cancer
- ☐ Hemorrhoids
- ☐ Anal fissure
- ☐ Anal fistula
- ☐ Stool incontinence
- ☐ Abnormal liver tests
- ☐ Fatty liver
- ☐ Hepatitis
- ☐ Cirrhosis

Cardiovascular

- ☐ High blood pressure
- ☐ Atrial fibrillation
- ☐ High cholesterol
- ☐ Rhythm disorder
- ☐ Heart attack
- ☐ Heart murmur
- ☐ Congestive heart failure

Pulmonary

- ☐ Sleep apnea
- ☐ Pulmonary embolism
- ☐ Asthma
- ☐ Sarcoidosis
- ☐ Emphysema
- ☐ Lung cancer
- ☐ Pneumonia
- ☐ Pleurisy

Neuropsychiatric

- ☐ Stroke or TIA
- ☐ Migraines
- ☐ Chronic headaches
- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar disorder
- ☐ Eating disorder
- ☐ Parkinson's disease
- ☐ Multiple Sclerosis
- ☐ Seizures
- ☐ Myasthenia gravis
- ☐ Dementia

Endocrine

- ☐ Diabetes
- ☐ Hypothyroidism
- ☐ Thyroid nodule
- ☐ Hyperthyroidism
- ☐ Goiter
- ☐ Pituitary problem
- ☐ Thyroid cancer
- ☐ Adrenal problem

Genitourinary

- ☐ Kidney disease
- ☐ Urinary tract infections
- ☐ Ovarian cyst(s)
- ☐ Ovarian cancer
- ☐ Kidney stones
- ☐ Bladder incontinence
- ☐ Uterine fibroids
- ☐ Uterine cancer
- ☐ Kidney tumors/cysts
- ☐ Prostate hypertrophy
- ☐ Abnormal pap smears
- ☐ Cervical cancer
- ☐ Bladder cancer
- ☐ Prostate cancer
- ☐ Cone biopsy/LEEP
- ☐ Endometriosis

Breast

- ☐ Fibrocystic breast changes
- ☐ Benign breast biopsy
- ☐ Breast cancer
- ☐ Chemo/radiation/surgery

Musculoskeletal

- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Rheumatoid arthritis
- ☐ Osteopenia
- ☐ Fibromyalgia
- ☐ Lupus
- ☐ Chronic back pain
- ☐ Gout

Eyes, Ears, Nose, and Throat

- ☐ Glaucoma
- ☐ Allergic rhinitis
- ☐ Sinusitis
- ☐ Oral thrush

Dermatologic

- ☐ Eczema
- ☐ Raynaud's syndrome
- ☐ Psoriasis
- ☐ Basal cell skin cancer
- ☐ Vitiligo
- ☐ Squamous cell cancer
- ☐ Alopecia
- ☐ Melanoma

Hematologic

- ☐ Anemia
- ☐ Blood transfusion
- ☐ Blood clot
- ☐ Hemochromatosis

Additional health history:

☐ Any other malignant tumors/cancers not previously mentioned: _____

☐ Any communicable disease, such as hepatitis, HIV, or sexually transmitted disease? _____

☐ Any other hospitalizations or medical conditions not previously mentioned: _____

PREVIOUS SURGERIES AND PROCEDURES

☐ Gallbladder	☐ Appendix	☐ Groin hernia repair	☐ Abdomen hernia repair
☐ Adhesion surgery	☐ Colon resection	☐ Hemorrhoid surgery	☐ Anti-reflux surgery
☐ Weight loss surgery	☐ D & C	☐ Uterine ablation	☐ C-section
☐ Tubal ligation	☐ Total hysterectomy	☐ Partial hysterectomy	☐ Vasectomy
☐ Prostate surgery	☐ Back surgery	☐ Lumpectomy	☐ Mastectomy
☐ Stent/angioplasty	☐ Heart bypass surgery	☐ Heart valve surgery	☐ Pacemaker
☐ Defibrillator	☐ Carotid surgery	☐ Vascular surgery	☐ Vein stripping

☐ Any other surgeries not previously mentioned: _____

MEDICATIONS

Please include all prescription and non-prescription medications (especially anti-inflammatories like Advil, Motrin, and Aspirin), as well as all supplements.

Medication Name	Dose and Frequency

SOCIAL HISTORY

Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed Children (ages): _____

Occupation: _____

Do you have any tattoos? ☐ Yes ☐ No

Do you use tobacco currently? ☐ Yes ☐ No

Did you ever use tobacco products? ☐ Yes ☐ No

When did you quit? _____

Number of packs per day? _____

How many years? _____

Do you drink alcohol? ☐ Yes ☐ No

Number of cups per day of caffeinated beverages? _____

How many glasses do you drink per day? _____

How many glasses do you drink per week? _____

Have you ever had a problem with alcohol or drug use? _____

FAMILY HISTORY

☐ Colon polyps	☐ Helicobacter pylori	☐ Crohn's disease	☐ Hepatitis B
☐ Colon cancer	☐ Stomach cancer	☐ Ulcerative colitis	☐ Hepatitis C
☐ Uterine cancer	☐ Ovarian cancer	☐ Celiac disease	☐ Hemochromatosis

If yes, list family members (i.e. mother, grandmother, sister, aunt) and age at diagnosis if polyps or cancers:

REVIEW OF SYSTEMS

General

☐ Fatigue ☐ Weakness ☐ Fever ☐ Night sweats

Cardiovascular

☐ Chest pain ☐ Palpitations ☐ Shortness of breath with exertion

☐ Ankle swelling/edema ☐ Varicose veins

Respiratory

☐ Cough ☐ Coughing blood ☐ Shortness of breath ☐ Wheezing

Neurologic

☐ Headaches ☐ Dizziness ☐ Localized numbness ☐ Speech difficulty

☐ Memory loss

Endocrine

☐ Cold intolerance ☐ Heat intolerance ☐ Excessive thirst ☐ Excessive hunger

☐ Dry skin ☐ Abnormal skin pigment ☐ Abnormal body hair ☐ Brittle hair

Genitourinary

☐ Blood in urine ☐ Burning urination ☐ Urinary incontinence ☐ Frequent urination

☐ Frequent urination at night

Males: ☐ Slow urinary stream ☐ Difficulty initiating urination ☐ Penile discharge

Females: ☐ Abnormal periods ☐ Menopause ☐ Vaginal discharge

Breast

☐ Lump(s) ☐ Pain ☐ Nipple discharge ☐ Enlargement (males)

Bones/Joints/Muscles

☐ Pain ☐ Swelling ☐ Stiffness

Oropharyngeal

☐ Mouth sores ☐ Tongue sores ☐ Tooth/gum problems

Skin

☐ Itching ☐ Rash ☐ Scaling

Hematology

☐ Swollen jaw ☐ Bruising ☐ Bleeding problems

Patient's Signature **Date**

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FINANCIAL POLICY

Thank you for choosing Comprehensive Gastrointestinal Health, LLC to assist with your healthcare needs. We are dedicated to providing you exceptional care to help achieve your wellness goals. Your understanding of our Financial Policy is important to our relationship. Please review the following information and sign below. A copy will be returned for your records. Please contact our Billing Department if you have any questions at **847.590.1500** or **jackie@cprmedicalbilling.com**.

IT IS YOUR RESPONSIBILITY TO:

Bring your **INSURANCE CARD** to every visit. Be prepared to pay your **CO-PAY** at each visit. Payment may be made by cash, check, or credit card. Unless you indicate otherwise, your credit card on file will be charged your co-pay amount on the day of your appointment. For medical care not covered under your insurance, payment in full is due at the time of the service (unless prior arrangements have been made with our billing department).

TYPES OF COVERAGE

SELF-PAY

"Self-Pay" is defined by Comprehensive Gastrointestinal Health, LLC as a **patient who does not have insurance or a program that accepts financial responsibility for the patient's bills**. In these circumstances, we may offer discounted self-pay rates and/or bundled service options. We expect payment at the time of service unless prior arrangements have been made with our Billing service. If you are unable to pay for necessary medical care, it is your responsibility to inform us prior to the visit. If you have supplemental insurance we will be happy to electronically submit it for you. You will receive a bill after your insurance has paid.

HMO/PPO

All co-payments are due at the time of the service. We are members of most but not all plans. You are responsible for verifying that we are providers for your plan. It is the patient's responsibility to know your insurance and to know when referrals or pre-authorization is required. **If you are an HMO member** you must provide us with a referral form at the time of the service. If you do not have a referral, your visit may be rescheduled, or you may be financially responsible.

INSURANCE

As a courtesy to our patients, we electronically submit your claims to your insurance company. Please remember, that your insurance policy is a contract between you and your insurance company. Comprehensive Gastrointestinal Health, LLC is not a part of that contract. We cannot bill your insurance company unless you provide us with all required insurance information. It is your responsibility to determine what benefits are covered by your insurance plan. The balance of your account is always your responsibility. If your insurance company has not paid your claim in 45 days, the balance will be transferred to you and becomes your responsibility.

MEDICARE

The providers at Comprehensive Gastrointestinal Health have chosen to opt out of participating with Medicare. This means that Medicare will not pay for you to see any of the providers at our office. Please refer to our Medicare Policy information for additional details.

CANCELLATION POLICY

Comprehensive Gastrointestinal Health relies on your commitment to keep your scheduled appointments. Some offices will double book appointments to prevent financial damage that occurs because of missed appointments. We have chosen not to overbook our appointment slots and prefer to spend the time necessary to provide thorough care to every individual. We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much-needed treatment. Conversely, the situation may arise where another patient fails to cancel with timely notice and we are unable to schedule you for a visit due to a seemingly "full" appointment book.

In an effort to prevent these adverse events from occurring, we require cancellations to be made 48 hours before your scheduled office appointment and 72 hours before your scheduled procedure appointment. If an office appointment is not canceled at least 48 hours in advance, you will be charged a $75 fee. If a procedure appointment is not canceled at least 72 hours in advance, you will be charged a $150 fee. We will ask for your credit card information at the time of making your appointment and securely store that in your electronic medical record. Signing this form will be an acknowledgment that you will be responsible for paying said fees prior to scheduling any future appointments. This fee will be your responsibility and will not be covered by insurance.

In addition, patients who do not show two or more times in a 12-month period, may be dismissed from the practice.

SURGICAL PROCEDURES

If you are scheduled for a procedure by our office, please be aware there are separate service components for which you will be billed separately:

PHYSICIAN'S PROFESSIONAL CHARGE

Your physician will bill this charge separately to you. This billing is for the physician's professional services that are provided during your procedure.

FACILITY CHARGE

This billing is for the use of the in-office endoscopy suite in which your procedure is being performed.

PATHOLOGY CHARGE

If you have a biopsy taken you will receive a bill from the laboratory and pathologist that processes your biopsy specimen.

ANESTHESIA PROFESSIONAL CHARGE

If your procedure utilizes the services of an anesthesiologist, this professional charge will be billed separately to you.

MEDICAL RECORD COPYING

All medical record copy requests must be in writing, dated, signed, and designate where the records are to be sent and what documents are to be copied. The medical information is accessible to the patient or their representative with signed authorization. The cost associated with copying medical records is made payable in advance and dependent on the number of pages. Our medical records department will provide you with the fee information and time frame for processing your request after review of your chart. Copies of records for the purpose of referral or continuation of patient's medical care do not have an associated cost.

RETURNED CHECKS

Returned checks will incur a $25.00 service fee for the first check. A second incident will result in a $50.00 service fee and patient will be on a cash or credit card payment basis only.

COLLECTION

In the event of non-payment of providers' bills, the Doctor shall be entitled to the right of recovery for all collection expenses, including court costs and reasonable attorney's fees, incurred for the purpose of obtaining payment of the amount due. If your account does go to a collection agency or we are listed in a bankruptcy suit you may be dismissed as a patient from our practice at your physician's discretion. You will receive a total of two billing statements, if your payment is not received within 30 days of the second billing statement, we will proceed with automatically charging your credit card on file. If that card is declined or we are unable to collect any past-due balance, we will proceed with our third-party collection efforts.

Please note, a 3% processing fee will automatically be added for credit card transactions.

Any questions about financial arrangements should be directed to the Billing Department. **Please sign indicating that you have read, understand and agree to this Financial Policy.**

Patient name: _____ Date: _____

Signature of Patient / Representative: _____

HEALTH INSURANCE PORTABILITY and ACCOUNTABILITY ACT (HIPAA)

Notice of Privacy Practices

The following is Comprehensive Gastrointestinal Health's HIPAA Notice of Privacy Practices and describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We are required by law to provide you with this notice that explains our privacy practices with regard to your medical information and how we may use and disclose your protected health information for treatment, payment, and for health care operations, as well as for other purposes that are permitted or required by law. You have certain rights regarding the privacy of your protected health information and we also describe those rights in this notice.

WAYS IN WHICH WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The following paragraphs describe different ways that we use and disclose your protected health information. We have provided an example for each category, but these examples are not meant to be exhaustive. All of the ways we are permitted to use and disclose your health information fall within one of these categories.

Treatment
We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. We will also disclose your health information to other physicians who may be treating you. Additionally, we may from time to time disclose your health information to another physician whom we have requested to be involved in your care. For example, we would disclose your health information to a specialist to whom we have referred you for a diagnosis to help in your treatment.

Payment
We will use and disclose your protected health information to obtain payment for the health care services we provide you. For example, we may include information with a bill to a third-party payer that identifies you, your diagnosis, procedures performed, and supplies used in rendering the service.

Health Care Operations
We will use and disclose your protected health information to support the business activities of our practice. For example — we may use medical information about you to review and evaluate our treatment and services or to evaluate our staff's performance while caring for you. In addition, we may disclose your health information to third party business associates who perform billing, consulting, or transcription, or other services for our practice.

OTHER WAYS WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

- Appointment Reminders
  — We will use and disclose your protected health information to contact you as a reminder about scheduled appointments or treatment.
- Treatment Alternatives
  — We will use and disclose your protected health information to tell you about or recommend possible alternative treatments or options that may be of interest to you.
- Others Involved in Your Care
  — We will use and disclose your protected health information to a family member, a relative, a close friend, or any other person you identify that is involved in your medical care or payment for care.
- Research
  — We will use and disclose your protected health information to researchers, provided the research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.
- As Required by Law
  — We will use and disclose your protected health information when required to by federal, state, or local law.
- To Avert a Serious Threat to Public Health or Safety
  — We will use and disclose your protected health information to public health authorities permitted to collect or receive the information for the purpose of controlling disease, injury, or disability. If directed by that health authority, we will also disclose your health information to a foreign government agency that is collaborating with the public health authority.
- Worker's Compensation
  — We will use and disclose your protected health information for worker's compensation or similar programs that provide benefits for work-related injuries or illness.
- Inmates
  — We will use and disclose your protected health information to a correctional institution or law enforcement official if you are an inmate of that correctional institution or under the custody of the law enforcement official. This information would be necessary for the institution to provide you with health care, to protect the health and safety of others, and/or for the safety and security of the correctional institution.

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of the practitioner or facility that compiled it, the information belongs to you. You have the right to:

- A Paper Copy of This Notice
  — You have the right to receive a paper copy of this notice upon request. You may obtain a copy by asking our receptionist at your next visit or by calling and asking us to mail you a copy.

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- **Inspect and Copy**
  - You have the right to inspect and copy the protected health information that we maintain about you in our designated record set for as long as we maintain that information. This designated record set includes your medical and billing records, as well as any other records we use for making decisions about you. Any psychotherapy notes that may have been included in records we received about you are not available for your inspection or copying, by law. We may charge you a fee for the costs of copying, mailing, or other supplies used in fulfilling your request.
  - If you wish to inspect or copy your medical information, you must submit your request in writing to our Privacy Officer: Attention: Privacy Officer, 40 Skokie Boulevard, Suite 110, Northbrook, Illinois 60062.
  - You may mail your request or bring it to our office. We will have 30 days to respond to your request for information that we maintain at our practice site. If the information is stored off-site, we are allowed up to 60 days to respond but must inform you of this delay.
- **Request Amendment**
  - You have the right to request that we amend your medical information if you feel that it is incomplete or inaccurate. You must make this request in writing to our operations manager, stating exactly what information is incomplete or inaccurate and the reasoning that supports your request.
  - We are permitted to deny your request if it is not in writing or does not include a reason to support the request. We may also deny your request if:
    - The information was not created by us, or the person who created it is no longer available to make the amendment.
    - The information is not part of the record which you are permitted to inspect and copy.
    - The information is not part of the designated record set kept by this practice or if it is the opinion of the opinion of the health care provider that the information is accurate and complete.
- **Request Restrictions**
  - You have the right to request a restriction of how we use or disclose your medical information for treatment, payment, or health care operations. For example, you could request that we not disclose information about a prior treatment to a family member or friend who may be involved in your care or payment for care. Your request must be made in writing to our operations manager.
  - We are not required to agree to your request if we feel it is in your best interest to use or disclose that information. If we do agree, we will comply with your request except for emergency treatment.
- **An Accounting of Disclosures**
  - You have the right to request a list of the disclosures of your health information we have made outside of our practice that were not for treatment, payment, or health care operations. Your request must be in writing and must state the time period for the requested information. You may not request information for any dates prior to April 14, 2003, nor for a period of time greater than six years (our legal obligation to retain information).
  - Your first request for a list of disclosures within a 12-month period will be free. If you request an addition list within 12-months of the first request, we may charge you a fee for the costs of providing the subsequent list. We will notify you of such costs and afford you the opportunity to withdraw your request before any costs are incurred.
- **Request Confidential Communications**
  - You have the right to request how we communicate with you to preserve your privacy. For example, you may request that we call you only at your work number, or by mail at a special address or postal box. Your request must be made in writing and must specify how or where we are to contact you. We will accommodate all reasonable requests.
- **File a Complaint**
  - If you believe we have violated your medical information privacy rights, you have the right to file a complaint with our practice or directly to the Secretary of Health and Human Services.
  - To file a complaint with our office, you must make it in writing within 180 days of the suspected violation. Provide as much detail as you can about the suspected violation and send it to our Privacy Officer.
- **Uses or Disclosures Not Covered**
  - Uses or disclosures of your health information not covered by this notice or the laws that apply to us may only be made with your written authorization. You may revoke such authorization in writing at any time and we will no longer disclose health information about you for the reasons stated in your written authorization. Disclosures made in reliance on the authorization prior to the revocation are not affected by the revocation.

FOR MORE INFORMATION

If you have questions or would like additional information, you may contact our Privacy Officer at 224.407.4400 or at 40 Skokie Boulevard, Suite 110, Northbrook, Illinois 60062.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT FOR RELEASE AND USE OF CONFIDENTIAL INFORMATION

NOTICE TO PATIENT:
We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. **Please sign this form to acknowledge receipt of the Notice.** You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information. I understand that the physician has reserved the 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 to me in a reasonable period of time in writing. 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 must be sent to the physician's office.

I hereby give my consent to Comprehensive Gastrointestinal Health, LLC to use or disclose, for the purpose of carrying out treatment, payment, or health care administration, all information contained in the patient record of:

NAME: _____ **DATE:** _____

SIGNATURE: _____

We cannot discuss your protected health information (PHI) with anyone other than yourself unless you authorize us to do so. Please list below names(s) of the individual(s) you authorize our office to discuss care with. Your PHI may be disclosed to the individual(s) listed below until you notify us otherwise in writing.

_____ _____

_____ _____

We will adhere to your communication preferences regarding voicemail.
We may leave messages on your voicemail with confidential information. ◯ Yes ◯ No

FOR OFFICE USE ONLY: We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

_____

_____

EMPLOYEE SIGNATURE: _____ **DATE:** _____

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CANCELLATION AND NO-SHOW POLICY

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much-needed treatment. Conversely, the situation may arise where another patient fails to cancel with timely notice and we are unable to schedule you for a visit due to a seemingly "full" appointment book. In an effort to prevent these adverse events from occurring, we require cancellations to be made 48 hours before your scheduled office appointment and 72 hours before your scheduled procedure appointment. If an office appointment is not canceled at least 48 hours in advance, you will be charged a $75 fee. If a procedure appointment is not canceled at least 72 hours in advance, you will be charged a $150 fee. We will ask for your credit card information at the time of making your appointment and securely store that in your electronic medical record. Signing this form will be an acknowledgment that you will be responsible to pay said fees prior to scheduling any future appointments. This fee will be your responsibility and will not be covered by insurance.

To cancel or reschedule an appointment, please call our office at 224.407.4400 or you may also email **info@compgihealth.com**.

Patient signature: _____ Date: _____