Orchard Medical Center
543 Orchard Street
Antioch, IL 60002
(847) 395-3322
Fax (847) 395-0921

Patient Information Booklet

The providers and staff of Orchard Medical Center would like to welcome you to our practice. Patient satisfaction is the commitment we make to every patient seen in our office.

We have put together a new patient information packet, which will help you to understand our policies and procedures. We want your experience here to be a pleasant and productive one. Please take a few minutes and read the enclosed information. If you have any questions regarding any our policies or processes please do not hesitate to call our office at 847-395-3322. We will be happy to assist you.

Appointments

Routine Appointments
Well child, school physicals, well women exams, and physicals should be scheduled 4-6 weeks in advance.

Follow-up Appointments
Follow-up appointments are appointments for chronic problems such as hypertension and diabetes. These appointments are scheduled in the time frame your provider indicates and should be scheduled in advance.

Nurse "Float" Appointments
If our provider or a referring physician has ordered lab tests, an EKG, an injection, etc. this is done Monday through Friday 7:30-11:00 and on Saturday 8:00-11:00. All patients must come with an order or have an order on file. Patients may not order their own labs.

Sick Appointments
Sick appointments are handled following a special protocol. Orchard Medical Center has developed a "same day" appointment protocol to meet the needs of our acutely ill patients. It is designed for the treatment of simple, acute illnesses. This would include symptoms that have arisen with the previous 24 to 48 hours. Typical "same day" problems include sore throat, cough, bladder infections, conjunctivitis (pink eye), rashes, muscle strains and sinusitis. Such conditions are considered non-life threatening, but severe enough to interfere with normal work activities or daily living. Chest pain or shortness of breath may be a symptom of a serious condition. For this reason, the best management begins with a call to 911.
"Same day" appointments are limited and are given out at 8:00am. Please try to call at this time to reserve your appointment slot.

Cancellation of an Appointment
In order to be respectful of the medical needs of all our patients please be courteous and call our office promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment. This is how we can best serve the needs of all our patients.

If it is necessary to cancel your scheduled appointment we require that you call 24 hours in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

If a patient is scheduling multiple family members at the same time, the rule of the practice it to have no more than 2 family members scheduled consecutively with a provider.

How to Cancel Your Appointment

To cancel appointments you may call 847-395-3322 or send us an email via our website – www.orchardmedicalcenter.com

Late Cancellations

Late cancellations will be considered as a "no show".

No Show Policy

A "no show" is someone who misses an appointment without canceling it 24 hours in advance. No-shows inconvenience those individuals who need access to medical care in a timely manner.

A failure to present at the time of a scheduled appointment will be recorded in our appointment scheduler as a "no show". The first time there is a "no show", the patient will be sent a letter alerting them to the fact that they have failed to show up for an appointment and did not cancel the appointment. If there is a second "no show", within 1 year, a fee of $50.00 will be billed to the patient, not the insurance company and this fee is required to be paid prior to scheduling the patients next appointment. Three "no shows", in 1 year, result in the termination from our practice.

Check-In

ID

Please provider a picture ID or your driver's license at check-in. We will need to verify that your name matches your insurance card and the name you are checking in with. This is prevent insurance fraud or identity theft.

Insurance Cards

Insurance cards are requested at each and every office visit. This includes both office and lab appointments. Without your insurance card, we will be unable to bill your insurance company. This could result in the services being billed to YOU, the patient and long delays in payment.

Co-payments

All co-payments must be made prior to seeing any provider. This is in accordance with both your contract and our contract with the insurance company. Orchard Medical Center will not bill for any co-payment due at the time of service. If you are unable to pay at the time of service, we will be happy to reschedule your appointment for a future date. If you have any questions regarding this policy contact the customer service phone number on the back of your insurance card. Thank you for your cooperation regarding this matter.

No Insurance

A fee is requested prior to seeing our providers. This fee is based on an average office visit charge. Additional fees may occur during your visit, please talk to our receptionist regarding the cost of these fees. All payments are due at the time of service.

Pharmacy Protocol

Prescription Refills

All prescription refill requests must be performed by your pharmacist. Please contact your pharmacy and they will fax over a refill request. Please allow 24-48 hours for all refills to be performed. We do not fill routine prescriptions on Saturday.

Controlled Substances

All controlled II substances must be on a written tamper proof paper. These can only be picked-up at our office. Orchard Medical Center will ask you to sign a release upon picking up your prescription. Orchard Medical Center also reserves the right to ask for proof of identification.

Mail-In Prescriptions

All patients are required to handle all mail-in prescriptions. We will take the medication requested, get approval from one of our providers and then call you when the prescription is ready to pick-up. Orchard Medical Center is not responsible for faxing or mailing prescriptions.

Samples
Orchard Medical Center is well aware of the cost of medications. We may provide some patients sample's of a medication at the start of a new prescription. We regretfully can not provide samples on a monthly basis. Please contact the pharmaceutical company of your particular medication and find out if they offer any discounted programs. Our providers will be happy to write a prescription for these programs but we can not initiate the program for our patients.

Referral Protocol

To obtain a referral an Orchard Medical Center provider or referring physician must approve and/or request a referral to be written. A referral may take between 7-10 business days. This is the approximate wait time for your insurance company to authorize the referral. We can not give out referrals that have not been authorized.

It is important that you do NOT make an appointment with a specialist or for a diagnostic test prior to receiving your referral. We cannot and will not back date or retroactive any referral. If you see a specialist or have a diagnostic procedure without obtaining an authorized referral, you will be held responsible for the payment of those services. There are no exceptions.

If your appointment is urgent, and your provider has ordered an urgent referral, your referral will have first precedents over all other referrals.

HIPPA Regulations

The Orchard Medical Center providers and staff follow strict HIPPA regulations. It is important that all patients sign our HIPPA acknowledgment form. It is equally important for patients to sign a release of information form indicating who you authorize Orchard Medical Center to release information to. Please log on to the following website to view the United States Department of Health and Human Services Official site with all the HIPPA regulations. http://www.hhs.gov/ocr/hipaa/

Request of Records Transfer

A record release form needs to be completed for all records transfers. A fee will be charged on a per page/per patient request. Please contact our office to determine the cost.

Forms Fees

These are the current fees that will be charged on our frequently requested forms:

1. **Routine school/work physical exam form: $25.00***
2. **Handicap forms: $5.00***
3. **Disability Forms: $35.00**
4. **Personal Letters (employment, airline, life insurance, etc. – non-excuse): $15.00**
5. **FMLA forms: $35.00**
6. **Assisted Living Forms: $15.00**

**** if not at time of appointment***

*****It is important to note that these fees are not covered by insurance and need to be paid at the time the form is submitted. We will not bill for these fees.*****

Fees on forms not listed above will be determined by Provider and the patient will be notified of the cost prior to the completion of the form.

Office Hours

<u>Monday – Friday</u>

7:30 – 12:00	**Nurse "float" appointments**
8:00 – 1:00 & 2:00 – 5:00	**Phone lines are open**
9:00 – 12:30 & 2:00 – 4:30	**Provider appointments available**

<u>Saturday</u>

7:30 am - Phone lines are open and the first 12 "same day" appointments are granted. Our phone lines will be turned back to service after that point.
8:00 – 10:00 – Provider appointments for "same day" appointments only

<u>Office Closed</u>

Our office is closed after 5:00 pm Monday – Friday and after 11:00 on Saturdays but a physician will be available and on-call every evening and weekend. Please call our regular office # to receive information on how to contact the on-call physician.

<u>Holiday Closings</u>

Our office will be closed for all major holidays. This includes New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving and Christmas Day. If Christmas Eve and New Year's Eve fall M-F then the office is open 9-12 on those days.

Contacting the Office after Hours

Website
The office will respond to website emails only between our regular office hours. Do not leave any urgent messages on an email. Call our office and leave a message with the answering service for the physician to be paged.

When To Have The Physician Paged
The on call physician should only be contacted for emergent or urgent medical problems. Please do not contact the physician for prescription refills (unless critical), appointment scheduling or to discuss non-urgent medical issues. If the physician responds to any of these calls they will notify you to contact the office during regular business hours.

Office Phone Numbers

Main Numbers

Office Phone	847-395-3322
Office Fax	847-395-0921

Staff Options

Practice Manager	Dena Graf	847-395-3322 x 110
Referral Coordinator	Julie/Rachael	847-395-3322 x 115
Medical Records	Diane/Jaime	847-395-3322
Lab Manager	Sue	847-395-3322 x 121

Billing Questions

Our billing is completed at ML Medical Billing. Please call 847 -770-6045 regarding any billing, statement or insurance questions. All payments are made directly to our office. Please mail checks to 543 Orchard Street – Antioch, Illinois 60002.

Thank You

Thank you for choosing Orchard Medical Center. We are happy that you have chosen our practice for your health care needs and we will make every attempt to ensure your satisfaction is met with each and every visit.

Dr. David Herman, Dr. Guy Abderholden, Dr. John Devaney, Dr. Elizabeth Soifer and Theodore Holroyd, PA-C

State of Illinois
Certificate of Child Health Examination

FOR USE IN DCFS LICENSED CHILD CARE FACILITIES
CFS 600
Rev 2/2013

Student's Name Last First Middle	Birth Date Month/Day/Year	Sex	Race/Ethnicity	School /Grade Level/ID#
Address Street City Zip Code	Parent/Guardian Telephone # Home Work			

IMMUNIZATIONS: To be completed by health care provider. Note the mo/da/yr for *every* dose administered. The day and month is required if you cannot determine if the vaccine was given *after* the minimum interval or age. **If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.**

Vaccine / Dose	1 MO DA YR	2 MO DA YR	3 MO DA YR	4 MO DA YR	5 MO DA YR	6 MO DA YR
DTP or **DTaP**						
Tdap; **Td** or Pediatric **DT** (Check specific type)	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV
Hib Haemophilus influenza type b						
Hepatitis B (HB)						
Varicella (Chickenpox)				COMMENTS:		
MMR Combined Measles Mumps. Rubella						
Single Antigen Vaccines	**Measles**	**Rubella**	**Mumps**			
Pneumococcal Conjugate						
Other/Specify Meningococcal, Hepatitis A, HPV, Influenza						

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below. If adding dates to the above immunization history section, put your initials by date(s) and sign here.)

Signature **Title** **Date**

Signature **Title** **Date**

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis is acceptable if verified by physician. *(All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)

***MEASLES (Rubeola)** MO DA YR **MUMPS** MO DA YR **VARICELLA** MO DA YR **Physician's Signature**

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.
Person signing below is verifying that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.

Date of Disease **Signature** **Title** **Date**

3. Laboratory confirmation (check one) ☐**Measles** ☐**Mumps** ☐**Rubella** ☐**Hepatitis B** ☐**Varicella**
Lab Results **Date** MO DA YR **(Attach copy of lab result)**

VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN

Date																			Code:
Age/ Grade																			P = Pass
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	F = Fail U = Unable to test R = Referred
Vision																			G/C =
Hearing																			Glasses/Contacts

Last First Middle	Birth Date Month/Day/ Year	Sex	School	Grade Level/ ID

HEALTH HISTORY **TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER**

ALLERGIES (Food, drug, insect, other)			**MEDICATION** (List all prescribed or taken on a regular basis.)		
Diagnosis of asthma? Child wakes during night coughing?	Yes No Yes No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes No	
Birth defects?	Yes No		Hospitalizations? When? What for?	Yes No	
Developmental delay?	Yes No				
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes No		Surgery? (List all.) When? What for?	Yes No	
Diabetes?	Yes No		Serious injury or illness?	Yes No	
Head injury/Concussion/Passed out?	Yes No		TB skin test positive (past/present)?	Yes* No	*If yes, refer to local health department.
Seizures? What are they like?	Yes No		TB disease (past or present)?	Yes* No	
Heart problem/Shortness of breath?	Yes No		Tobacco use (type, frequency)?	Yes No	
Heart murmur/High blood pressure?	Yes No		Alcohol/Drug use?	Yes No	
Dizziness or chest pain with exercise?	Yes No		Family history of sudden death before age 50? (Cause?)	Yes No	
Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor ______ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)			Dental ☐ Braces ☐ Bridge ☐ Plate Other		
Ear/Hearing problems?	Yes No		Information may be shared with appropriate personnel for health and educational purposes. **Parent/Guardian Signature** **Date**		
Bone/Joint problem/injury/scoliosis?	Yes No				

PHYSICAL EXAMINATION REQUIREMENTS **Entire section below to be completed by MD/DO/APN/PA**

HEAD CIRCUMFERENCE if < 2-3 years old **HEIGHT** **WEIGHT** **BMI** **B/P**

DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) **BMI>85% age/sex** Yes☐ No☐ And any two of the following: **Family History** Yes ☐ No ☐ **Ethnic Minority** Yes☐ No ☐ **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes☐ No ☐ **At Risk** Yes ☐ No ☐

LEAD RISK QUESTIONNAIRE Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. (Blood test required if resides in Chicago or high risk zip code.)

Questionnaire Administered ? Yes ☐ No ☐ **Blood Test Indicated?** Yes ☐ No ☐ **Blood Test Date** **Result**

TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. **No test needed** ☐ **Test performed** ☐

Skin Test: Date Read / / **Result: Positive** ☐ **Negative** ☐ **mm** ______________

Blood Test: Date Reported / / **Result: Positive** ☐ **Negative** ☐ **Value** ______________

LAB TESTS (Recommended)	Date	Results		Date	Results
Hemoglobin or Hematocrit			Sickle Cell (when indicated)		
Urinalysis			Developmental Screening Tool		

SYSTEM REVIEW	**Normal**	**Comments/Follow-up/Needs**		**Normal**	**Comments/Follow-up/Needs**
Skin			**Endocrine**		
Ears			**Gastrointestinal**		
Eyes		Amblyopia Yes☐ No☐	**Genito-Urinary**		LMP
Nose			**Neurological**		
Throat			**Musculoskeletal**		
Mouth/Dental			**Spinal Exam**		
Cardiovascular/HTN			**Nutritional status**		
Respiratory		☐ Diagnosis of Asthma	**Mental Health**		
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g. Short Acting Beta Agonist) ☐ Controller medication (e.g. inhaled corticosteroid)			**Other**		

NEEDS/MODIFICATIONS required in the school setting

DIETARY Needs/Restrictions

SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?
If you would like to discuss this student's health with school or school health personnel, check title: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g. ,seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?
Yes ☐ **No** ☐ If yes, please describe.

On the basis of the examination on this day, I approve this child's participation in (If No or Modified please attach explanation.)
PHYSICAL EDUCATION **Yes** ☐ **No** ☐ **Modified** ☐ **INTERSCHOLASTIC SPORTS** **Yes** ☐ **No** ☐ **Limited** ☐

Print Name (MD,DO, APN, PA) **Signature** **Date**

Address **Phone**

(Complete Both Sides)