

<i>If you are accessing this form online, print the form. Complete pages 1 and 2; sign page 2. Complete page 3 if it is applicable. Read pages 4-8 and complete, initial and sign where indicated.</i>	Today's Date:
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1. Patient information:

Last Name:		First Name: (Legal)		M.I.:
Street:				
City:		State:	Zip Code:	
Phone (Home):		Phone (Work):		
Phone (Cell/Pager):		Email:		
Social Security #	Birth-date:	Marital Status:	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced
	MO DAY YEAR		<input type="checkbox"/> Single	<input type="checkbox"/> Widowed
	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female			
Employer's Name:		<input type="checkbox"/> Patient is a minor. See below	Occupation:	
Employer's Address:		State:	Zip Code:	
Employer's Phone:				

2. Please complete below if patient is a minor:

Last Name of Mother/Legal Guardian:		First Name: (Legal)		M.I.:
<input type="checkbox"/> RESPONSIBLE FOR PAYMENT		<input type="checkbox"/> Address if different from patient's:		
Phone (Home):	Phone (Cell/Pager):	Phone (Work):		
Last Name of Father/Legal Guardian:		First Name: (Legal)		M.I.:
<input type="checkbox"/> RESPONSIBLE FOR PAYMENT		<input type="checkbox"/> Address if different from patient's:		
Phone (Home):	Phone (Cell/Pager):	Phone (Work):		
Name of Other Party Responsible for Payment (if applicable):				
Responsible Party Information:		Phone (Home):		
Street Address:		City:	State:	Zip:
Employer's Name		Employer's Phone:		
Street Address:		City:	State:	Zip:

3. Emergency contact not living with you:

Name:	Address:
Relation:	Cell/Phone/Pager:

4. How were you referred to this office?

<input type="checkbox"/> Primary Care Physician SEE BELOW		<input type="checkbox"/> Other Physician NAME:	
<input type="checkbox"/> Friend		<input type="checkbox"/> Other Patient	
<input type="checkbox"/> Emergency Rm.		<input type="checkbox"/> Yellow Pages	
<input type="checkbox"/> Insurance Co.		<input type="checkbox"/> Other:	
Primary Care Physician Information:		Other Physician Information:	
Name:		Name:	
Address:		Address:	
Phone:		Phone:	

5. Please describe the problem or injury:

Date of Injury or onset of symptoms:			
Is this a Workers Compensation Claim?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is this an automobile accident?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
Will a third party be responsible for payment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you or will you file a lawsuit in connection with this problem/injury?
			<input type="checkbox"/> Yes <input type="checkbox"/> No

If you answered "yes" to any of the above questions, please also complete appropriate sections on page 3.

6. Insurance Information:

Primary Insurance Company Name:		<input type="checkbox"/> PPO <input type="checkbox"/> HMO <input type="checkbox"/> POS <input type="checkbox"/> Other:	
Street:	City:	State:	Zip Code:
Insured's Name:	Birth-date: <u> </u> <u> </u> <u> </u>	Social Security #: <u> </u> <u> </u> <u> </u>	
ID#:	Group #:	Policy Effective Date:	
Relation to Patient:	Marital Status:	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced
		<input type="checkbox"/> Single	<input type="checkbox"/> Widowed
Insured's Employer:	Address:		
Secondary Insurance Company Name:		<input type="checkbox"/> PPO <input type="checkbox"/> HMO <input type="checkbox"/> POS <input type="checkbox"/> Other:	
If your secondary insurance is Medicare, please also complete question #1 on the next page.			
Street:	City:	State:	Zip Code:
Insured's Name:	Birth-date: <u> </u> <u> </u> <u> </u>	Social Security #: <u> </u> <u> </u> <u> </u>	
ID#:	Group #:	Policy Effective Date:	
Relation to Patient:	Marital Status:	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced
		<input type="checkbox"/> Single	<input type="checkbox"/> Widowed
Insured's Employer:	Address:		

THE INFORMATION PROVIDED ABOVE IS TRUE AND ACCURATE:

Name of person completing this form: _____
 Signature of person completing this form: _____

Please complete this section if :

- Medicare is your secondary insurance
- You have a Workers Compensation claim
- You're here due to an auto accident
- You have a third party liability claim

1. Is Medicare your secondary insurance?		<input type="checkbox"/> No	<input type="checkbox"/> Yes
If yes, complete below.			
(1) Have you enrolled in MediGap?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Don't Know
(2) Are either you or your spouse still employed?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
(3) Is the patient a disabled person under age 65?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
(4) Is this a 3 rd party liability case?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	(please also answer Question #4 below)
If you answered "no" to all questions above, please explain why Medicare is your secondary insurance:			
2. Is this condition covered under Workers Compensation?		<input type="checkbox"/> No	<input type="checkbox"/> Yes - Workers Comp Claim # _____
If yes, complete below.			
Date of Injury:		Have you contacted your employer?	<input type="checkbox"/> No <input type="checkbox"/> Yes
State where injury happened:	<input type="checkbox"/> IL <input type="checkbox"/> Other: _____	Name/Phone number of person at your place of employment who authorized your treatment:	
Responsible Party/Insurance:			
Address:			
Phone Number:			
Name of Claims Manager or Contact Person:			
3. Is this condition due to an automobile accident?		<input type="checkbox"/> No	<input type="checkbox"/> Yes If yes, complete below.
Date of Injury:		Have you contacted the insurance company regarding this accident?	<input type="checkbox"/> No <input type="checkbox"/> Yes
State where accident happened:	<input type="checkbox"/> IL <input type="checkbox"/> Other: _____		
Auto insurance company responsible:			
Billing address for claims:			
Phone for Claims Examiner:			
Policy Number:		Claim Number:	
Insured Party:		Insured's Date of Birth: _____	
		MO DAY YEAR	
Insured Party's Address:			
4. Is this condition due to the liability of a 3 rd party?		<input type="checkbox"/> No	
<i>(Will your bills be paid by a party other than you, your own insurance or auto insurance?)</i>		<input type="checkbox"/> Yes If yes, complete below.	
Date of Injury:	Your Attorney's Name:		
Your Attorney's Address:	Your Attorney's Phone:		

NOTE: IBJI does not bill 3rd parties. We will first bill your insurance, then you directly.

Health Care Consent

Patient Name: _____ Date of Birth: _____

CONSENT TO TREAT: I, for myself (or the patient named above) hereby consent to such medical treatment and diagnostic procedures as necessary and appropriate for my condition or illness based on the judgment of my physician(s), to be performed by the physician(s), physician assistant(s), nurse(s) or other health care provider(s). I have had, and will continue to have, an opportunity to discuss treatment options with my health care provider, ask questions regarding such treatment options and understand the options discussed.

RESPONSIBILITY FOR PAYMENT: The patient, or legal guardian, is always responsible for payment. In consideration of services to be rendered, the undersigned agrees, as patient (or guarantor for patient) to pay Illinois Bone and Joint Institute (IBJI) for all services and supplies provided to me (or the patient, as applicable) at the established rates, including any deductible, co-payment or other charges, as permitted by third party payors. I accept responsibility for any costs, including attorneys' fees incurred by IBJI in the collection of these charges. I understand that if I do not consent to the release of records, or later revoke such consent, I am fully responsible for payment of all charges for examination, diagnosis and treatment received. I certify that the information given by me for purposes of payment is, to the best of my knowledge, complete and accurate.

ASSIGNMENT OF BENEFITS: In consideration of services rendered, I hereby assign and authorize direct payment to IBJI of any insurance, health plan or third party payor benefits otherwise payable to me or on my behalf (or on behalf of the patient) for these services.

MEDICARE PAYMENT AND ASSIGNMENT OF BENEFITS (if applicable): I request that payment of authorized Medicare benefits be made on my behalf for services furnished to me and be assigned to IBJI. I certify that the information given by me in applying for such benefits is correct and that I have completed a Medicare questionnaire. I authorize any holder of medical or other information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed for payment of benefits. I authorize the Social Security Administration to release information about my entitlement to benefits to my provider of health care services.

RELEASE OF MEDICAL INFORMATION: I hereby authorize IBJI to release any and all pertinent information contained in my medical records (current and prior) for:

Treatment: Includes activities performed by health care practitioners in providing, coordinating or managing care with third parties and consultations with other health care providers.

Payment: Includes activities involved in receiving payment for services rendered and any required review of care for medical necessity, justification of charges, pre-certification and pre-authorization.

Health care operations: Includes the necessary administrative and business functions of IBJI.

By initialing the diagnoses/condition(s) below, I **do not consent** to the release of such medical information, if any, to third party payors and understand that I am personally responsible for payment:

HIV/AIDS Drug/alcohol diagnoses, treatment or referral Mental Health Genetic Testing

The consent to release information expires one year after the date of signature below. I understand that I have the right to revoke this consent provided that I do so in writing, except to the extent that IBJI has already used/disclosed the information relied upon by this consent.

PERSONAL BELONGINGS: I assume full responsibility for all items of personal property that I have brought to IBJI and release IBJI of all liability in the event of loss or damage to such property.

Signature of Patient: _____ Date: _____

Signature of Patient's Authorized Representative: _____ Date: _____

Name of Patient's Authorized Representative: _____

**Consent to the Use and Disclosure of Protected Health Information
For Treatment, Payment and/or Health Care Operations**

Patient Name: _____ Date of Birth: _____

I understand that Illinois Bone & Joint Institute (IBJI) originates and maintains protected health information for the purposes of treatment, payment and health care operations as explained below:

- Treatment includes activities performed by a health care provider, practitioner, office staff and other health care professionals providing care, coordinating or managing care with third parties and consultations with other health care providers. This consent also includes any practitioner who provides coverage for IBJI by telephone as the on-call practitioner.
- Payment includes activities involved in making a determination of eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities that may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization.
- Health care operations includes the necessary administrative and business functions of IBJI.

By initialing at the end of this paragraph, I acknowledge that I have received a copy of the IBJI Notice of Privacy Practices (NPP). I understand this document provides additional information about the use/disclosure of my protected health information. INITIAL HERE: _____

I understand that I am not required to waive my rights under the Privacy Rule as a condition for treatment. Further, I understand that since IBJI has the right to change its Privacy Practice in accordance with the law, the terms contained in the Notice may change as well. IBJI will provide a copy of the most updated Notice on my first visit as required by law and upon my request.

As more fully explained in the Notice, you have the right to request restrictions on how IBJI can use/disclose your protected health information for treatment, payment and/or health care operations. IBJI is not required to agree with your request. If your request is approved, IBJI is required to comply with your restriction unless the information is needed for emergency treatment. Restrictions should be noticed and attached to this form. These restrictions will stay in effect until otherwise terminated. Any other practitioner who provides coverage for IBJI is required to use/disclose your protected health information as stated in the Notice.

By initialing the diagnoses/condition(s) below, I **do not consent** to the release of such medical information, if any, to third party payors and understand that I am personally responsible for payment:

HIV/AIDS Drug/alcohol diagnoses, treatment or referral Mental Health Genetic Testing

The consent to release information expires one year after the date of signature below. I understand that I have the right to revoke this consent provided that I do so in writing, except to the extent that IBJI has already used/disclosed the information relied upon by this consent.

Signature of Patient _____ Date: _____

Signature of Patient's Authorized Representative: _____ Date: _____

Name of Patient's Authorized Representative: _____

Phone Message and Contact Authorization

Patient Name: _____ Date of Birth: _____

The doctors and staff of Illinois Bone & Joint Institute (circle one) **DO DO NOT** have my permission to leave messages containing medical and/or financial information on my answering machine.

Note: If permission is not granted, only the date, time and location of your appointment will be left on your answering machine.

I give authorization for the following people to discuss my medical and/or financial information with doctors and staff of Illinois Bone & Joint Institute.

Name	Relationship	Phone
(1) _____	_____	_____
(2) _____	_____	_____
(3) _____	_____	_____

Signature of Patient _____ Date: _____

Signature of Patient's Authorized Representative: _____ Date: _____

Name of Patient's Authorized Representative: _____

**Acknowledgement of Receipt of Illinois Bone & Joint Institute's
Financial Policy Summary**

Patient Name: _____ Date of Birth: _____

**Illinois Bone & Joint Institute
FINANCIAL POLICY**

Thank you for choosing us as your care provider. We are committed to the successful treatment of your medical condition. Please understand that payment of your bill is considered part of your treatment. Your clear understanding of our Financial Policy is important to our professional relationship. Please call our billing department if you have any questions. They may be reached at 847-720-7170.

- ▶ Full payment is due at the time of service for self-pay patients or if insurance information (and copy of insurance card) have NOT been provided.
- ▶ We accept cash and Visa/Mastercard. Some offices also accept Discover card and/or checks. Please confirm with our reception staff.
- ▶ All patients must complete our "patient registration form" and other forms provided at the time of registration.
- ▶ For cases in which we bill insurance directly, we **MUST HAVE A COPY OF THE CURRENT INSURANCE ID CARD.**
- ▶ ***If payment is not received from the insurance carrier or other responsible party within 90 days, you ACKNOWLEDGE THAT WE HAVE THE RIGHT TO BILL YOU DIRECTLY.***
- ▶ Please notify us immediately of any changes in your insurance information or coverage.
- ▶ At least 24 hours' notice is required for copies of medical records or x-rays and there may be a nominal fee.
- ▶ You are ultimately responsible for payment of all services.

UCR (Usual and Customary Rates)

We are committed to providing the best treatment possible for our patients and we charge what is usual and customary for our area.

Medicare

We accept Medicare assignment. As a Medicare patient, you are responsible only for the difference between Medicare's approved charge and the amount Medicare pays, your deductible and charges for any service not covered by Medicare. If you have supplemental insurance, we will bill it directly for you. You will receive a bill after your insurance has paid.

If you are in a skilled medical nursing facility (permanently or temporarily residing in a nursing home or rehabilitation center):	
Facility Name:	
Facility Address:	

Page 2 of Financial Policy Summary

HMO/PPO

ALL CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE. IF YOU DO NOT KNOW YOUR CO-PAY YOU MAY USE OUR PHONE TO FIND OUT. We are a member of most, but not all, insurance plans. You are responsible for verifying that we are an in-network provider under your plan. If you are an HMO member, you will not be billed as long as you have obtained the necessary referrals. All patients will be responsible for their co-payments, co-insurance and deductibles as applicable and as long as they have verified with their insurance company that our physician is in their plan.

Workers' Compensation

If you are here as a result of a work-related injury, we will require information regarding both health insurance and your employer's Workers' Compensation insurance. We will also need to verify that your employer assumes responsibility for charges incurred. If we cannot verify employer responsibility or we are unable to obtain information on your employer's Workers' Compensation insurance, as a courtesy we will bill your health insurance carrier. If payment is not received from these third parties within 90 days, we have the right to bill you directly.

Accident Claims

If you are here as a result of an accident claim, we will require information regarding both health insurance and accident insurance. In addition, we will need the name, address and phone number of your attorney. In the case of a lawsuit, we may need to file liens for payment. If payment is not received from these third parties within 90 days, we have the right to bill you directly.

I understand that if the office agrees to bill insurance as a courtesy to me, I must submit information as needed to guarantee payment for services rendered to me. I understand that I am ultimately responsible for payment of all services.

Signature of Patient: _____ Date: _____

Signature of Patient's Authorized Representative: _____ Date: _____

Name of Patient's Authorized Representative: _____