PATIENT REGISTRATION

FORM A-9

Welcome to our office. We are committed to providing the best, most comprehensive care possible. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and is released only with your consent. Please fill in the blanks below the line.

Patient Name | Today's Date | Date of Birth | Sex | Age

Parent if Patient is a Minor

E-Mail Address:

Home Address | City | State | Zip

Mailing Address if Different | City | State | Zip

Cell Phone #:

Occupation | Employer's Name

Spouse Name | Employer

Primary Care Physician's Name

How did you hear about our office: Google ___ Facebook ___ Instagram ____ Magazine Ad ____

Patient/Dr. Referral ___

If Patient/Physician Referral, please provide their name so we can thank them:

NOTIFY IN CASE OF EMERGENCY

Name | Relationship

Phone

FINANCIAL INFORMATION: PERSON RESPONSIBLE FOR FEES

Name | Telephone

Address | City | State | Zip

Insurance Company

Subscriber's Name | Subscriber's Date of Birth

Insurance ID No.: | Group #:

Secondary Insurance

Subscriber's Name | Subscriber's Date of Birth

Office Use Only:

Insurance Verified By: ____ Medicare: Yes/No _____ Labor Fund: Yes/No _____

MVA_____ Work Comp_____ Ready for EHR: Yes/No Checked _____

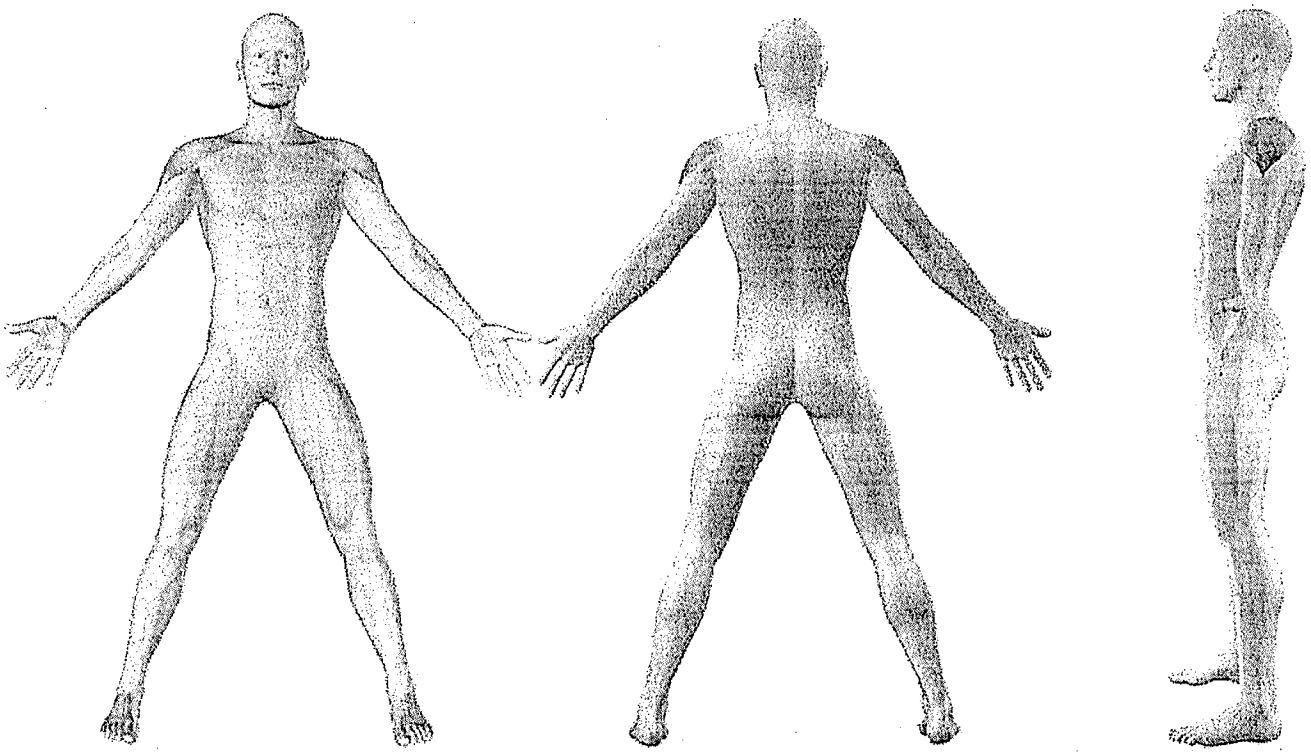
Patient Registration Continued. . .

Please briefly describe what problem brings you to see us today _____

When did this problem start _____

Please circle how this issue came on: Suddenly Built Up Over Several Days Gradually Worse Over a Long Time
Please circle how your injury occurred: At Work At Home Auto Accident Other:_____

Using the figures below, please circle the areas of pain/discomfort



Please help us understand your personal circumstances related to these issues: Circle below

I am: Working F/T Working P/T Homemaker F/T Student Unemployed Retired
Occupation:_____

Age: _____ Single Married Divorced Widowed

Patient History:
Are you allergic to any medications: NO YES Please list_____

Please mark any of the follow health conditions that you have now or have had in the past:

__ Severe Headaches	__ Chest Pain	__ Asthma	__ Arthritis
__ Arrhythmia	__ Fatigue	__ Stroke	__Heart Murmur
__ Hypertension	__ Renal Disease	__ Heart Disease	__ Endocrine Disorders
__ Hypothyroid	__ Hyperthyroid	__ Gout	__ Kidney Stones
__ Shortness of breath	__ Mental Illness	__ Anemia	__ HIV/AIDS
__Drug / Alcohol addiction	__ Liver Disease	__ Dizziness/Fainting	__Epilepsy

Please list any medications you are currently taking (prescription and OTC)

Name of Medication	Doses / Day

Family History: Has anyone in your family suffered from:

Condition	Who?	Condition	Who?
Heart Disease		Epilepsy	
Hypertension/ High Blood Pressure		Bleeding or Clotting Disorders	
Stroke		Kidney Disease	
Cancer		Epilepsy	
Diabetes		Thyroid Disease	

Do you require any special care or have any concerns that might affect your treatment or recovery? NO YES
IF yes, please describe: _____

I verify this information is correct and thorough.

Patient Signature: _____ **Date:**_____

Printed Name: _____

Acknowledgement of Financial Policy & Agreement for Advanced Physical Medicine of St. Charles

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 & that your understanding of our Financial Policy is important to our professional relationship. Please call our billing department if you have any questions: 630-377-7788 extension 102. The authorization to release medical records is necessary to process any claims that may be incurred and assign Advanced Physical Medicine of St. Charles medical reimbursement benefits under the insurance policy(ies) for services rendered. The patient, or legal guardian is always responsible for payment. In consideration of services to be rendered, you, as the undersigned patient or guarantor for patient, agree to pay Advanced Physical Medicine of St. Charles for all services & supplies provided to you, as established by your insurance policy, including any deductibles, co-payments, or other charges. Furthermore, by signing below, you certify that the information provided for purposes of payment is, to the best of your knowledge, complete and accurate. Additionally:

- Full payment is due at the time of service for self-pay patients or if insurance information is NOT provided.
- We accept cash, check, or credit card payments
- No-Show fees will be applied for appointments missed without notice. $30 for 30min massage/ $50 for 60min massage appointments. Initial: _____
- All patients must complete our Patient Registration Form & other intake forms at the time of registration.
- For cases in which we bill insurance directly, we must have a copy of the current insurance card.
- Please notify us immediately if your insurance information/policy/coverage changes.

PPO Insurance

ALL CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE. We are a member of most insurance plans. Although we do our best to verify your benefits as an added benefit to you, you are ultimately responsible for verifying that we are an in-network provider under your plan & for understanding your insurance policy. We will always do our best to work with you and when applicable, educate you on your policy.

HMO Insurance

We do not accept HMO insurance plans. We are happy to work with you as a cash patient.

Medicare

We accept Medicare. As a Medicare patient, you are responsible for the difference between Medicare's approved charge and the amount Medicare pays, your deductible & charges/services 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.

Personal Injury/Worker's Compensation

If you are here due to a work-related injury or a personal/MVA injury, we require information regarding those claims, as well as your health insurance information. At the time of your appointment, you must provide us with the following:

- For Worker's Compensation: Employer's Name and contact information, Claim number, adjuster's name & phone number.
- For Worker's Compensation: If there is a dispute between your health insurer & your employer, you are responsible for your healthcare bills.
- For Personal Injury: Auto Insurance Carrier, Med-Pay Claim number/third party information, adjuster's name & phone number.
- For Personal Injury: APM of STC will place a "Physicians Lien" on your claim/case for payment.
- Our office is well-versed in handling Work Comp &/or PI cases. We diligently work to communicate with the various insurance carriers, adjusters, and attorneys to receive/rectify your accrued medical bills. However, your medical bills are ultimately your financial responsibility.

By signing below, you are indicating that you have read the above statements and agree to the Financial Policies set forth by Advanced Physical Medicine of St. Charles.

Name_____ Date _____

Relationship to Patient _____

Advanced Physical Medicine of St. Charles

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a Federal program that requests all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your personal health information (PHI) is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and examples of how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this would include referring you to an orthopedic specialist.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities and utilization review. An example of this would be sending your insurance company a bill for your visit and/or verifying coverage.
- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and customer service. An example of this would be reviewing patient satisfaction surveys.
- Advanced Physical Medicine of St. Charles may also disclose your PHI for law enforcement and other legitimate reasons although we will do our best to assure continued confidentiality.

We may contact you by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services.

You have the following rights with respect to your PHI:

- The right to reasonable requests to receive confidential communications of Protected Health Information by alternative means.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your Protected Health Information and to provide you with notice of our legal duties and our privacy practice with respect to PHI. Signing this form verifies that you are in receipt of this information.

Signature _____ Date_____

Relationship to patient _____