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				
Patient's Social Security Number:		E-Mail Address:		
Home Address	City	State	Zip	
Mailing Address if Different	City	State	Zip	
Cell Phone #:	Home Phone #:		Work Phone #:	
Preferred Phone to be reached: Cell Home Work (circle one please)				
Occupation		Employer's Name		
Employer's Address	City	State	Zip	
Spouse Name		Employer		
Primary Care Physician's Name				
Whom May We Thank for Referring You to Our Practice?				

NOTIFY IN CASE OF EMERGENCY

Name	Relationship
Phone	

FINANCIAL INFORMATION: PERSON RESPONSIBLE FOR FEES

Name		Telephone	
Address	City	State	Zip
Insurance Company		Claim Address	
Subscriber's Name	Subscriber's Date of Birth	Subscriber's SSN#.	
Insurance ID No.:			
Secondary Insurance		Claim Address	
Subscriber's Name	Subscriber's Date of Birth	Subscriber's SSN#	

WORKERS COMPENSATION INJURY

Were You Injured on the Job? YES NO	Have you Informed Your Employer? YES NO
Date of Original Injury:	
Workers Compensation Insurance Carrier:	
Workers Compensation Claim Number:	
Workers Compensation Adjuster Information Name of Adjuster:	Phone Number:
Are you or have you received treatment from another specialist? YES NO If yes, please provide name & phone number of facilities:	

WHAT PROBLEM BRINGS YOU TO SEE US TODAY?

WHEN DID THIS PROBLEM START?

Did it come on: ☐ Suddenly ☐ Built up over several days ☐ Gradually worse over a long time.

If you were injured was it: ☐ At Work ☐ At Home ☐ Due to Auto Accident ☐ Other Injury

ON THE FIGURES AT THE RIGHT, PLEASE MARK YOUR AREA(S) OF PAIN OR DISCOMFORT.

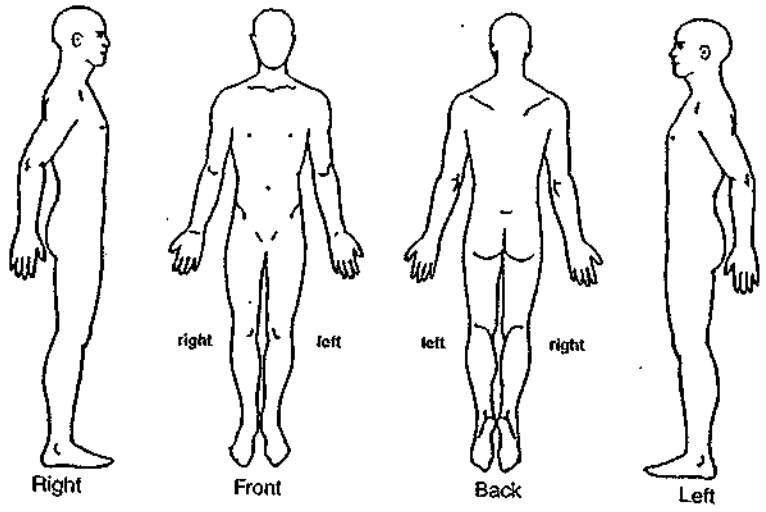
+++ Burning /// Stabbing

.... Pins & needles xxx No feeling

Circle the areas (if more than one) of pain and tell us on a scale of 1 to 10, with 1 being light pain to 10 being very severe, how severe is your pain in each area most of the time and how frequent.

AREA 1 pain is (1-10) ___ Constant or Intermittent

AREA 2 pain is (1-10) ___ Constant or Intermittent



Please help us understand your pain. Circle the words for each area that best describes your pain and activity during your day.

Area 1 is: Worse in AM At Night After exertion It is: Sharp Stabbing Dull Achy Throbbing Burning Tingling

Area 2 is: Worse in AM At Night After exertion It is: Sharp Stabbing Dull Achy Throbbing Burning Tingling

Area 3 is: Worse in AM At Night After exertion It is: Sharp Stabbing Dull Achy Throbbing Burning Tingling

I have difficulty with: Walking Sitting Standing Driving a car Sleeping My daily routine Bladder Control Depression

I currently am : Ambulatory without assistance Need to use: Support Brace _____ Walker Cane Crutches Wheelchair

Please help us better understand your personal circumstances and assist us in providing you customized treatment and care.

I Am Now: ☐ Working Full Time Part Time ☐ Homemaker ☐ Full Time Student ☐ Unemployed ☐ Retired

Occupation: _____

☐ On sick leave ☐ On Temp disability ☐ On Full Disability My last day worked was _____

Age _____ Single Married Separated Filing for Divorce Divorced

Please feel free to discuss with us any situation in your personal relationships that may affect your recovery.

I Now ○ Smoke ___ Packs per day Stopped _____ ○ Use Alcohol Type and Amt _____

○ Consume Caffeine: Type/ Amt _____ ○ Use recreational drugs _____

am now or have in the past been : ○ Addicted to drugs alcohol ○ Treated for alcohol or drug addiction

WOMEN ONLY: Can you become pregnant? YES NO Date of last period _____ Normal Yes No

f not, why? _____ Date of last Mammogram _____ Normal Yes No

re you now or could you be pregnant ? ? YES NO Pap Smear _____ Normal Yes No

atient _____ Primary Intake History

Pertinent History: Please advise us of any special circumstances, previous tests, therapy or conditions:

Are you allergic to any medications? NO YES (If yes, please list all that you are allergic to below)

If you previously had any of the following procedures, please list the date and place they were performed:

PROCEDURE	DATE(S)	PLACE PERFORMED
X-Rays		
C.T. / MRI		
Myelogram		
Ultrasound		
E.M.G.		
Treatment by Another Physician		
For what?		

PLEASE MARK ANY CONDITION THAT YOU NOW HAVE OR HAVE RECOVERED FROM IN THE RECENT PAST:

Severe headaches / Chest pain / Angina / Kidney Stones / Digestive problems / Hypertension / Renal disease Gout / Stroke / Heart murmur / Diabetes / Arthritis / Epilepsy / Arrhythmia / Endocrine disease / HIV / AIDS Fatigue / Congenital heart disease / Urinary, genital problems / Dizziness / Fainting / Anemia / Reumatic fever / Scarlet fever / Prostate problems / Ulcers / Gall Stones / Sexual dysfunction / Venereal disease / Pancreatitis Shortness of breath / Menstrual dysfunction / Mental Illness / Asthma / Liver disease / Alcohol or Drug problems.

CURRENT MEDICATIONS PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING. *(Prescription and over the counter)*

Name of medication and Strength	# of doses / day

HOSPITALIZATION and SURGERY:

PLEASE LIST ALL SURGERY AND ANY PERIODS OF HOSPITALIZATION (give dates)

FAMILY HISTORY: Has anyone in your immediate family (mother, father, grandparents, brothers, sisters, children) had:

condition	who?	condition	who?
Heart Disease		Epilepsy	
Hypertension		Glaucoma	
Stroke		Bleeding disorders	
Cancer		Kidney disease	
Diabetes		Thyroid disease	

Do you require special care or have any concerns that might affect your treatment or recovery? NO YES (If yes please describe)

Thank you for assisting us in gathering the information our medical providers need to help determine a personal treatment plan for you. To verify that the information is correct as given to us by you, please affix your signature in the area (x) provided below.

Patient Signature: X

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 _____