Advanced Physical Medicine & Rehab

2500 W Higgins Road, Suite 310, Hoffman Estates IL 60169

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.

Patient Name	Today's Date	Date of Birth	Sex	Age

Marital Status: ◯Single ◯Married (Spouse Name: _____)

◯Divorced ◯Widowed ◯Separated

◯Minor - (Parent/Guardian name _____)

Patient's Social Security Number

Address (Street, City, State, Zip)

Home Phone	Cell Phone	Work Phone

E-Mail Address	Occupation

Employer Name / Address

Primary Care Physician's Name

Whom May We Thank for Referring You to Our Practice?

NOTIFY IN CASE OF EMERGENCY

Name	Relationship to you:

Address (Street, City, State, Zip)

Home Telephone	Work Telephone

In case of a medical emergency, if the patient is of school age (15+) it is okay to treat in my absence:

X_____ _____

Signature of Patient, Parent or Guardian Date

Office Use: PATIENT ID #_____

What problem brings you to see us today?

_____

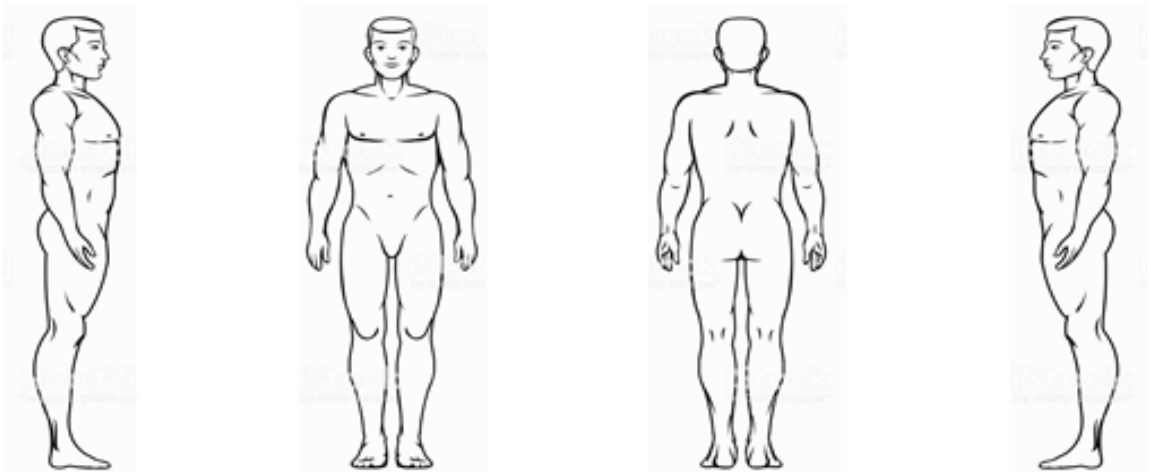
When did it start? _____

Did it come on ◯Suddenly ◯Built up over time ◯Gradually worse over a long time

If you were injured, was it ◯At work ◯At Home ◯Due to Auto Accident ◯Other

Mark area(s) of pain/discomfort on figures below

Codes: **+++** Burning **///** Stabbing **●●●** Pins/Needles **XXX** No Feelings/Numb



RIGHT FRONT BACK LEFT

1

Help us understand your pain:

• Pain level (1-light pain >> 10-severe pain) = _____ ◯Constant ◯Intermittent

• Pain is: ◯Sharp ◯Stabbing ◯Dull ◯Achy ◯Throbbing ◯Burning ◯Tingling

• Worse at ◯AM? ◯Night? ◯After exertion?

2

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• Worse at ◯AM? ◯Night? ◯After exertion?

I have difficulty with: ◯Walking ◯Sitting ◯Standing ◯Driving a Car ◯Sleeping ◯My Daily Routine ◯Bladder Control Depression

Current Mobility: ◯Move without Assistance

Or Need to Use: ◯Support Brace ◯Walker ◯Cane ◯Crutches ◯Wheelchair

Help us Better Understand Your Personal Circumstances:

◯Work Full Time ◯Work Part Time ◯Homemaker ◯Full Time Student ◯Unemployed ◯Retired

Occupation: _____ ◯Sick Leave ◯Temporary Disability ◯Full Disability

For Women: Are you now or could you become pregnant? ◯Yes ◯No

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

Procedure	Date	Place Performed
X-Rays / CT / MRI		
Myelogram		
EMG		
Blood or Plasma Transfusion	*Last Chest X-ray:*	

Mark any conditions that you have **NOW** or have recovered from in the **RECENT PAST**

◯ Anemia	◯ Digestive Problems	◯ Gout	◯ Liver Disease	◯ Rheumatic Fever
◯ Arthritis	◯ Diphtheria	◯ Heart Condition	◯ Low Blood Pressure	◯ Scarlet Fever
◯ Arrhythmia	◯ Dizziness	◯ Hemorrhoids	◯ Measles	◯ Small Pox
◯ Asthma	◯ Eczema	◯ Hepatitis	◯ Migraines	◯ Stroke
◯ Back Pain	◯ Endocrine Disease	◯ Hernia	◯ Mitral Valve Prolapses	◯ Thyroid Disease
◯ Bleeding Tendency	◯ Epilepsy	◯ High Blood Pressure	◯ Mumps	◯ Tuberculosis
◯ Bronchitis	◯ Fainting	◯ HIV/AIDS	◯ Pancreatitis	◯ Ulcers
◯ Cancer	◯ Fatigue	◯ Hives	◯ Pneumonia	◯ Venereal Disease
◯ Chicken Pox	◯ GallStones	◯ Infectious Mono	◯ Polio	◯ Whooping Cough
◯ Diabetes	◯ Glaucoma	◯ Kidney Disease	◯ Prostate Problems	◯ Other _____

Please list all surgery, serious illnesses and any periods of hospitalization *(Diagnosis/When/Hospital City/State):*

_____

_____

Current Medication You are Taking:

Medication	Dosage / Day	Medication	Dosage / Day

Patient Social History

Alcohol	◯ Never	◯ Rarely	◯ Moderate	◯ Daily
Tobacco	◯ Never	◯ Rarely	◯ Moderate	◯ Daily
Drugs	◯ Never	◯ Rarely	◯ Moderate	◯ Daily
Excessive Exposure (at home or work) to:	◯ Fumes	◯ Dust	◯ Solvents	◯ Noise

Family History

	Age	Disease	If Deceased, Cause of Death
Father			
Mother			
Siblings			
Maternal Grandparents			
Paternal Grandparents			

Circle Any Problem Areas (5-worst / 1-least) *Circle all that apply

Eyes/Ears/Nose/Throat/Respiratory		Muscular/Skeletal		Neurological	
Asthma	5 4 3 2 1	Muscle Aches	5 4 3 2 1	Headaches	5 4 3 2 1
Stuffy Nose	5 4 3 2 1	Fibromyalgia	5 4 3 2 1	Migraines	5 4 3 2 1
Hay Fever	5 4 3 2 1	Arthritis	5 4 3 2 1	Dizziness	5 4 3 2 1
Sore Throat	5 4 3 2 1	Joint Pain	5 4 3 2 1	Numbness	5 4 3 2 1
Chronic Cough	5 4 3 2 1	Low Back Pain	5 4 3 2 1	Tingling	5 4 3 2 1
Chest Congestion	5 4 3 2 1	Neck Pain	5 4 3 2 1	Pins/Needles (in hands or feet)	5 4 3 2 1
Frequent Sneezing	5 4 3 2 1	Wrist / Hand Pain	5 4 3 2 1	General	
Itchy / Watery Eyes	5 4 3 2 1	Elbow Pain	5 4 3 2 1	Fatigue	5 4 3 2 1
Drainage	5 4 3 2 1	Shoulder Pain	5 4 3 2 1	Malaise	5 4 3 2 1
Earache / Ear Infection	5 4 3 2 1	Hip Pain	5 4 3 2 1	Weakness, Tiredness	5 4 3 2 1
Itching	5 4 3 2 1	Knee Pain	5 4 3 2 1	Lightheadedness	5 4 3 2 1
Hoarseness	5 4 3 2 1	Ankle / Foot Pain	5 4 3 2 1	Irritability	5 4 3 2 1
Shortness of Breath	5 4 3 2 1	Pain b/t Shoulder Blades	5 4 3 2 1	Constipation	5 4 3 2 1
Wheezing	5 4 3 2 1			Diarrhea	5 4 3 2 1
				Feeling Foggy	5 4 3 2 1
				Forgetfulness	5 4 3 2 1

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____

Signature of Patient, Parent or Guardian Date

Acknowledgement of Receipt of Notice of Privacy Practices

Our privacy brochure is located at our front desk and is available to all patients. Please sign below that you received/viewed a copy of this office's Notice of Privacy Practices.

_____ _____

Signature of Patient, Parent or Guardian Date

HIPAA Compliance

In order to keep our office running efficiently, please sign this waiver allowing us to keep a daily record of your appointments. This will keep us up to date with current HIPAA regulations.

_____ _____

Signature of Patient, Parent or Guardian Date

Office Use: PATIENT ID #_____

ASSIGNMENT OF HEALTH PLAN BENEFITS & RIGHTS
as well as an
APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE
AND AN ERISA/PPACA REPRESENTATIVE & BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **Advanced Physical Medicine and Rehab** as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been*** **or** ***will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

_____ _____

Signature of Patient, Parent or Guardian Date

Office Use: PATIENT ID #_____

Advanced Physical Medicine & Rehab Financial Policies

BASIC POLICY: Payment for service is due in full at the time service is provided in our office.

MISSED APPOINTMENTS: In fairness to other patients and the doctor, we require at least 24 hours' notice to cancel appointments. You may be charged $35 for missed appointments.

PATIENTS WITH INSURANCE: APM&R provides insurance verification as a courtesy. This is NOT a guarantee of payment/accuracy. We strongly advise the patient to contact their insurance company to confirm all benefit information.

You are considered a cash/self-pay patient until you bring in your completed insurance information, and we qualify and accept your insurance coverage. If during your course of care, your insurance coverage is terminated or interrupted, you will be considered a cash case and services are expected to be paid for at the time of service. Should any of the services that are paid for as a cash case be reprocessed by your insurance company due to termination error, any payments made by you will be refunded once your claims have been processed.

Our fees are considered usual, customary and reasonable by most companies, and therefore, are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on arbitrary schedule of fees bearing no relationship to the current standard of care in this area.

If you discontinue care for any reason other than discharge by your provider, all outstanding balances will become immediately due and payable in full by you.

If a payment is returned by your bank or creditor unpaid for any reason, we reserve the right to charge the fees to you, along with an additional fee of $30.00. Any and all financial information provided by you will be protected as part of your personal health information and additionally protected under federal HIPAA regulation and therefore, subject to a $10,000 fine to anyone who misuses this information.

If you have an outstanding balance, are no longer receiving care in our office and there has been no attempt by you to communicate with our office to rectify your balance, your account will be turned over to collections after (90) days and you will be responsible for up to 30% of the balance in collection fees in addition to the original balance.

NONCOVERED SERVICES: Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

MEDICAID PATIENTS: We do NOT accept Medicaid. All fees of services rendered are due at time of service.

PERSONAL INJURY CASES: We will bill your medical payment portion of your personal auto insurance or your major medical insurance carrier for services related to your personal injury case. If third party insurance is being billed, we will submit a lien for payment upon settlement of the case.

WORKER'S COMPENSATION: If your injury is work-related, we will need the case number, carrier name and contact information prior to any visits in order to bill the worker's compensation insurance company.

MEDICARE PATIENTS: We will bill Medicare for you. Medicare will crossover claims to secondary insurance for you. If you do not have a secondary insurance, you will be responsible for the amount not covered by Medicare. ***SIGNATURE ON FILE: I request payment of authorized Medicare benefits be made either to me or on my behalf to Advanced Physical Medicine & Rehab for any services furnished me by the listed provider/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.***

I have read, understood, and agree to the above financial policy for payment of professional fees. The patient is ultimately responsible for all professional fees.

_____ _____ _____

Signature of Patient, Parent or Guardian | Patient Date of Birth | Today's Date