Illinois Neuro & Physical Rehabilitation

199 S. Addison Road, Suite 105-106
Wood Dale, IL 60191
Phone: 630-766-1552 Fax: 630-766-4220

CONFIDENTIAL PATIENT FILE INFORMATION

Today's Date: _____ Birth date: _____ Patient File #: _____
Last Name: _____ First _____ Middle Initial: _____ SS#:_____
Address: _____ City: _____ State: _____ Zip: _____
Phone: Home: _____ Cell:_____ Email: _____
Sex: **M** or **F** Marital Status: _____ Number of Children: _____ Referred By: _____
Employer: _____ Occupation: _____
Work Phone: _____ Driver's License #:_____
Name of Spouse: _____ SS #: _____
Employer: _____ Occupation: _____
Name of Nearest Relative: _____ Phone: _____

{ } CHECK HERE IF YOU DO NOT WANT MESSAGES LEFT FOR YOU OR EMAILS

Reason for Visit is a result of (Please circle): Work, Sports, Auto, Trauma, or Chronic.
Briefly explain what happened:
_____
_____
Please describe the pain and its location:
_____
_____
When did the condition begin: _____/_____/_____

Is the condition getting worse? { } Yes { } No { } Constant { } Comes and goes
Does your pain radiate? { } Yes { } No If yes, where?_____

Is this condition interfering with your (Please Circle all that apply): Work, Sleep, or Daily Routine.
If so, please explain:_____

Have you had this or similar conditions in the past: { } Yes { } No
If so, please explain: _____

List other Doctors seen for this condition: _____

Rate your pain using the pain scale of **0 = no pain**; **10 = Worst pain imaginable**
0 1 2 3 4 5 6 7 8 9 10

HEALTH HISTORY

Are you taking any of the following medications?
{ } Nerve pills { } Pain killers (including aspirin) { } Muscle relaxers { } Stimulants { } Blood Thinners
{ } Tranquilizers { } Insulin { } Other(s)_____
Are you allergic to any medications? ____No ____ Yes / What kind? _____
Do you smoke? { } No { } Yes / How much? _____How long? _____ Date of last physical:_____
For women: Are you taking Birth Control? { } Yes { } No
Are you pregnant? { } No { } Yes/how long?_____ Nursing? { } Yes { } No

Have you ever had any of the following diseases/medical condition(s)? (Mark all that apply):

____Heart Attack/ Stroke
____Congenital Heart Defect
____Alcohol / Drug Abuse
____HIV+ / AIDS
____Frequent Neck Pain
____High/Low Blood Pressure
____Severe/Frequent Headaches
____Fainting/Seizures/Epilepsy
____Diabetes / Tuberculosis
____Heart Surgery / Pacemaker
____Mitral Valve Prolapse
____Venereal Disease
____Shingles
____Emphysema / Glaucoma
____Psychiatric Problems
____Kidney Problems
____Sinus Problems
____Difficulty Breathing
____Artificial Bones / Joints
____Heart Murmur
____Artificial Valves
____Hepatitis
____Cancer
____Anemia
____Rheumatic Fever
____Ulcers / Colitis
____Asthma
____Chemotherapy
____Arthritis

ACCOUNT INFORMATION:

Name: _____ Relation: _____

Billing Address: _____ City: _____ State: _____ Zip: _____

SS#: _____ Driver's License #: _____

Work Phone #: _____ Payment Method: { } Cash { } Check { } Credit Card

CC # (if accepted): _____ Exp: _____

{ } **I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered (if offered at this office).**

IN EVENT OF EMERGENCY: Contact Name: _____ Relation: _____

Home Phone #: _____ Cell Phone #: _____

INSURANCE INFORMATION: ***(Clinic policy requires payment arrangements to be made on first visit)***

Name of Party Responsible for Payment: _____ Relation: _____

Insurance Company Name: _____ Address: _____

City: _____ Zip: _____ Phone #: _____

Insured's SS#:_____Group # (Plan, Local, or Policy #): _____ DOB: _____/_____/_____

Insured's Employer: _____

(Please inform the front desk of 2nd Insurance source)

We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient. Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for any expenses incurred in collecting your account. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Patient (Guardian's) Signature: _____ Date: _____

Illinois Neuro & Physical Rehabilitation, Ltd.
199 S. Addison Road #105-106 / Wood Dale IL 60191
Ph: 630-766-1552 / Fax: 630-766-4220

HIPPA CONSENT

FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION
TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, _____, hereby state that by signing this Consent, acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.
4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.
5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is no required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
6. I understand that this Consent is valid for seven (7) years. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.
7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____
Name of Individual (Printed) Signature of Individual

_____ _____
Signature of Legal Representative Relationship
(i.e. Attorney-In-Fact, Guardian, Parent if minor)

Date Signed: _____/_____/_____ Witness: _____

INFORMED CONSENT FOR CHIROPRACTIC, MEDICAL AND/OR PHYSICAL THERAPY TREATMENT AND CARE

I hereby consent to the performance of the medical treatment and therapy I will be receiving that may include, but not limited to, chiropractic adjustments, modalities, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible). These treatments may be performed by a licensed doctor of chiropractic, medical physician, licensed physical therapist / physical therapist assistant, massage therapist and/or chiropractic assistant who now or in the future treat me while employed by, working or associated with or serving as back-up for the providers named below, including those working at the clinic or office listed below.

I have had an opportunity to discuss with Illinois Neuro & Physical Rehabilitation, Ltd., and/or with any other office or clinic personnel the nature and the purpose of chiropractic adjustments and other procedures.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic and physical therapy, there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon facts then known, is in my best interests.

I have read or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient's Name: _____

Patient's Signature: _____ Date: _____/_____/_____

Witness to Signature: _____ Date: _____/_____/_____

TO BE COMPLETED BY THE PATIENT'S REPRESENTATIVE IF PATIENT IS A MINOR OR PHYSICALLY OR LEGALLY INCAPACITATED.

Patient's Name: _____

Signature of Representative: _____Date Signed: _____/_____/_____

Witness to Signature: _____ Date Signed: _____/_____/_____

Illinois Neuro & Physical Rehabilitation, Ltd.
199 S. Addison Road, Suite 105-106, Wood Dale IL 60191 / Ph: 630-766-1552

Illinois Neuro & Physical Rehabilition, Ltd.
199 S. Addison Road, Suite 105-106, Wood Dale IL 60191
Ph: 630-766-1552 / Fax: 630-766-4220

I, _____, authorize Illinois Neuro & Physical Rehabilitation, Ltd., to take x-rays for my condition. These x-rays are valuable information in order to assist my doctor in his/her evaluation of an initial treatment plan.

PATIENT'S SIGNATURE: _____ DATE: _____/_____/_____

WITNESS: _____ DATE: _____/_____/_____

Females Only:
This is to certify that to the best of my knowledge I am not pregnant and Illinois Neuro & Physical Rehabilitation, Ltd., has my permission to take x-rays.

PATIENT NAME: _____ DATE: _____/_____/_____

PATIENT SIGNATURE: _____ DATE: _____/_____/_____

WITNESS: _____ DATE: _____/_____/_____

I understand the x-rays and other pertinent information related to my treatment will be presented to a Board Certified Radiologist for analysis. I further understand 1) the sole purpose of this analysis is to identify spinal subluxations, biomechanical abnormalities and pathology analysis, 2) this information is valuable in order to assist my doctor in his/her evaluation of an initial treatment plan, as well as modification to this plan during the course of treatment.

PATIENT'S SIGNATURE: _____ DATE: _____/_____/_____

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS VALID
AND EFFECTIVE AS THE ORIGINAL.

OFFICE POLICY REGARDING RELEASE OF X-RAYS

X-rays taken here at this office are part of your permanent medical file and we are required by law to maintain them:

1. Original x-rays are **NEVER** released to the patients and/or other doctors.
2. Copies can be made and released only after authorization has been executed.

* There is a per film charge for processing and materials – payable in advance. Patients suspending or terminating care must pay any balance due prior to receiving copies.
* There are NO EXCEPTIONS to the above policy.

PATIENT'S SIGNATURE: _____ DATE: _____/_____/_____

ILLINOIS NEURO & PHYSICAL REHABILITATION, LTD.
FINANCIAL POLICY

Thank you for choosing Illinois Neuro & Physical Rehabilitation, LTD., as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you read and sign prior to any treatment. All patients must complete our Information and Insurance form before seeing the doctor.

WE ACCEPT: Visa, Mastercard, Discover, Cash or check

Regarding Insurance

We may accept assignment of insurance benefits. The only exception is if the initial visit is during a promotional event that we have various times throughout the year. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information including a copy of your insurance card and an original claim form. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignment of benefits, we require that you be pre-approved on one extended payment plan or provide a credit card with authorization to bill that account for the balance. If your insurance company has not paid your account in full within 45 days, the balance will be automatically transferred to your credit card or the extended payment plan. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance. Regarding Insurance Plans we are a participating provider. All co-pays and deductibles are due prior to treatment unless otherwise specified (at the end of every week). In the event that your insurance coverage changes to a plan where we are not participating providers, refer to above paragraph.

Personal Injuries

If you are involved in a car accident or personal injury, it is your responsibility to provide our office with the following information. We require you to call the insurance companies involved whether it be your auto carrier or the other party involved in the accident. The insurance companies must know that you are seeking medical treatment. We ask that you set up a claim to use your own auto medical payments coverage to assist in processing your bills in a timely fashion. Please understand that your case may take up to 3 years to settle. The responsible party will NOT pay your medical bill as you receive treatment. Please understand that we are here to make things easier for you. If you do not have medical payment coverage on your policy, you must bring in any documentation supporting that fact. You must bring in a copy of the police report / accident or incident report. If you retain an attorney to represent you, please give us the name, address and phone number. If you happen to change your attorney throughout your case, please inform us of that new information. You must also provide a copy of your health insurance card to be kept on file in case we may need to use it if the other insurance companies do not pay. PLEASE UNDERSTAND THAT THE BALANCE IS YOUR RESPONSIBILITY IN ANY CASE WHERE THE INSURANCE CARRIERS DO NOT COVER YOUR MEDICAL BILLS. A CREDIT CARD NUMBER MUST BE KEPT ON FILE TO ENSURE PAYMENT OF YOUR ACCOUNT.

Workman's Compensation

Please be advised that you must call your Human Resource Department and report your injury. This will ensure that a first Incident Report has been sent to your employer's Workman's Compensation insurance carrier. This is your responsibility. You must also understand that the carrier may have a Nurse or Case Manager handling your file. Please keep them informed of your status. In a situation where your claim is denied for pre-existing issues or the insurance deems your treatment not medically necessary, you ARE RESPONSIBLE for your balance. Ultimately your medical bills are your responsibility although we will do our best to take care of the financial matter for you. Please remember that it is a courtesy from our office to do the billing for you. Please work with us to avoid any problems that arise. ONCE AGAIN, A CREDIT CARD NUMBER MUST BE KEPT ON FILE TO ENSURE PAYMENT OF THE ACCOUNT.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Adult Patients

Adult patients are responsible for full payment at the time of service.

Minor Patients

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-approved to an approved credit plan, Visa/Mastercard, or payment by cash or check at the time of service has been verified.

Missed Appointments

$35.00 Fee will apply for any appointments not canceled with at least 24 hours advanced notice. Please help us serve you better by keeping your scheduled appointments.

_____Patient's Initial

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. I have read the Financial Policy, understand and agree to this Financial Policy.

_____ **DATE: _____/_____/_____**

Signature of Patient or Responsible Party

_____ **DATE: _____/_____/_____**

Signature of Co-Responsible Party

_____ **DATE: _____/_____/_____**

Signature of Witness

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR
PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

RE:
Patient: _____

Employer: _____

Claim/Group #: _____

SS# / ID#: _____

I hereby instruct and direct the _____ Insurance Company to pay by check made out and mailed directly to:

Illinois Neuro & Physical Rehabilitation, Ltd.
199 S. Addison Road, #105-106
Wood Dale, IL 60191
630-766-1552

Or

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make the check out to me and mail it as follows:

C/O Illinois Neuro & Physical Rehabilitation, Ltd.
199 S. Addison Road, #105-106
Wood Dale, IL 60191
630-766-1552

The professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Dated at ___*Illinois Neuro & Physical Rehabilitation, Ltd.*__ this _____ day of _____ 20____.

_____ _____
Signature of Policyholder Witness

_____
Signature of Claimant, if other than Policyholder