



REHABILITATION SERVICES - REGISTRATION FORM

- Have you ever been treated *here* before? **Yes** **No**
- Have you had therapy *elsewhere* this year? **Yes** **No**
- If so, was it for the same injury or diagnosis as your current appointments? **Yes** **No**
- Are you currently receiving home health care? **Yes** **No**
- Are you residing in a medical nursing facility either temporarily or permanently? **Yes** **No**
- Do you have a pacemaker or metal implant? **Yes** **No**
- Is your injury work related? **Yes** **No**

Date of Birth: _____ / _____ / _____

Email*: _____

**Your email will only be used to communicate with you about your care, account, IBI Service surveys, or education.*

Cell Phone #: _____

In case of emergency please contact: _____ Phone: _____

IBJI Referring Doctor: _____

IBJI Doctor's Office Location: _____

Body Part you are being seen for: _____

24 hour notice for cancellation required. Failure to comply may result in a \$20 cancellation/no show charge.

Signed: _____ **Date:** _____



MEDICAL HISTORY

Please check any conditions that apply to you:

- | | | |
|--|--|---|
| <input type="checkbox"/> Bone or joint disease | <input type="checkbox"/> Heart condition | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Tendonitis/bursitis | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Broken/fractured bones | <input type="checkbox"/> Lymphedema | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Spasms/cramps | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Low blood pressure |
| <input type="checkbox"/> Sprains/strains | <input type="checkbox"/> Herpes/shingles | <input type="checkbox"/> Pregnant |
| <input type="checkbox"/> Low back, hip, leg pain | <input type="checkbox"/> Sleep Disorders | <input type="checkbox"/> Rashes |
| <input type="checkbox"/> Neck, shoulder, arm pain | <input type="checkbox"/> Depression | <input type="checkbox"/> Athletes Foot |
| <input type="checkbox"/> Headaches/head injuries | <input type="checkbox"/> Psychological | <input type="checkbox"/> Warts |
| <input type="checkbox"/> Jaw pain/TMJ | <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Bladder problems |
| <input type="checkbox"/> Lupus | <input type="checkbox"/> Drug/Alcohol abuse | <input type="checkbox"/> Urinary tract infection |
| <input type="checkbox"/> Aids/HIV | <input type="checkbox"/> Nicotine/caffeine addiction | <input type="checkbox"/> Nausea/vomiting |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Gas/constipation |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Allergies/skin allergies |
| <input type="checkbox"/> Cancer/tumors | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Breathing difficulties/asthma | <input type="checkbox"/> Tingling | |

If you have checked any of the above, please explain: _____

Is there any additional information that might affect your condition or rehabilitation? _____

Please list any medications you are taking presently: _____

Do you have any known drug allergies? Yes No Please list: _____

List any surgeries or significant past medical history: _____

What testing have you received for this problem? X-Ray MRI CT Scan BoneScan



HEALTH CARE CONSENT

Patient Name: _____ **MR#:** _____

(for office use only)

Date of Birth: _____ / _____ / _____

CONSENT TO EVALUATE/TREAT: I, for myself (or the patient named above), hereby consent to such medical evaluation and/or treatment and diagnostic procedures (e.g. x-rays, MRI, videotaping) 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.

This consent expires one year after the date of signature.

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 Authorized Representative _____ Date _____

Name of Authorized Representative _____

Relationship of Authorized Representative _____



NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Name: _____ **MR#:** _____ **Date of Birth:** ____/____/____
(for office use only)

The **Notice of Privacy Practice (NPP)** tells you how we use and share your health records. It also describes your rights with respect to your health records. **Please read it.**

- We will use and share your health records to treat you and to bill you for the services we provide.
- We will use and share your health records to run our business.
- We will use and share your health records as required by law.

I understand that the NPP is available on the Illinois Bone and Joint Institute website (www.ibji.com) and at my physician's office. **I acknowledge receipt of the IBJI Notice of Privacy Practices (NPP).**

Signature of Patient _____ Date _____

Signature of Authorized Representative _____ Date _____

Name of Authorized Representative _____ Relationship _____

PHONE MESSAGE AND CONTACT AUTHORIZATION

Please CHECK the appropriate answer below:

Do the physicians and staff of Illinois Bone and Joint Institute have your permission to leave messages containing medical and/or financial information on your **answering machine**?

- | | | |
|---|-------------------------------------|-------------------------------------|
| <input type="checkbox"/> At home | <input type="checkbox"/> Yes | <input type="checkbox"/> No* |
| <input type="checkbox"/> At work | <input type="checkbox"/> Yes | <input type="checkbox"/> No* |

*If you check "No", the date, time and location of appointments will be left on your answering machine.

Please complete below: **I give authorization to the doctors and staff of Illinois Bone and Joint Institute to discuss my medical and/or financial information with the following people:**

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

I understand that it is my responsibility to inform IBJI of any desired changes in this authorization.

Note: This authorization expires one year after the date of signature.

Signature _____ Date _____



ACKNOWLEDGEMENT OF RECEIPT OF ILLINOIS BONE & JOINT INSTITUTE'S FINANCIAL POLICY

Patient Name: _____ **Date of Birth:** ____/____/____

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.

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 Illinois Bone and Joint Institute (IBJI) for all services and supplies provided to you (or the patient as applicable) at the established rates, including any deductibles, co-payment or other charges, as permitted by third party payors. By signing this financial policy summary, you accept responsibility for any costs, including attorney's fees incurred by IBJI in the collection of these charges for examination, diagnosis and treatment received. Furthermore, you certify that the information given by you 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 (and copy of insurance card) has NOT been provided.
- 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.
- 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.

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.

HMO/PPO: ALL CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE. As the owner of your policy, 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.

Insurance Disputes: If there is a dispute regarding the payment of your insurance or certain workers' compensation claim, IBJI has the right to bill you prior to the resolution of that dispute and to anticipate payments from you.

I understand that the office agrees to bill insurance carrier as a courtesy to me. I must submit information as needed by my insurance company or IBJI 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 Authorized Representative _____ Date _____

Print Name of Authorized Representative _____ Relationship _____