

Office use only: MR #: _____ ID verified: _____

Date: _____

1. Patient information:

Last Name		First Name (Legal)		M.I.
Street				
City		State	Zip	
Phone Home		Work	Cell	
Your email will only be used to communicate with you about your care, account, IBJI service surveys, or education.				Email Address:
SSN	Birth Date	Gender	Marital Status	
		M F		
Employer		Occupation		
Employer Address:		City		
State	Zip	Employer Phone		

Is your injury due to: Work accident Auto accident 3rd Party Liability (eg: claim against another party)

2. Your health insurance: (If you are not the policy holder, please complete the section below.)

Primary Insurance Company Name	Phone:
Policyholder's Name:	Birth-date: <u> </u> <u> </u> <u> </u> MO DAY YEAR
Relationship to Patient:	
Insured's Employer:	Phone:
Secondary Insurance Company Name:	Phone:
Insured's Name:	Birth Date: <u> </u> <u> </u> <u> </u> MO DAY YEAR
Relationship to Patient:	
Insured's Employer:	Phone:

3. How did you hear about us?

<input type="checkbox"/> Friend <input type="checkbox"/> Other Patient <input type="checkbox"/> Emergency Rm. <input type="checkbox"/> IBJI Website <input type="checkbox"/> Insurance Co. <input type="checkbox"/> Other:	
Have you previously been treated by any IBJI physician <input type="checkbox"/> No <input type="checkbox"/> Yes Which Doctor?	
Primary Care Physician Information:	Referring Physician or other Medical Professional:
Name:	Name:
Address:	Address:
Phone:	Phone:

4. Please complete below if patient is a minor:

Last Name of Mother/Legal Guardian		First Name (Legal)		M.I.
<input type="checkbox"/> RESPONSIBLE FOR PAYMENT	If yes, please provide Social Security Number:		DOB	
Street	City	State	Zip	
Phone H	W	Cell	Email	
Last Name of Father/Legal Guardian		First Name (Legal)		M.I.
<input type="checkbox"/> RESPONSIBLE FOR PAYMENT	If yes, please provide Social Security Number:		DOB	
Street	City	State	Zip	
Phone H	W	Cell	Email	

If you are in a skilled medical nursing facility (permanently or temporarily residing in a nursing home or rehabilitation center):

Facility Name and Address:

THE INFORMATION PROVIDED ABOVE IS TRUE AND ACCURATE:

Name of person completing this form

Relationship to Patient

Signature of person completing this form

Date

Health Care Consent

Patient Name: _____ **MR #:** _____ **Date of Birth:** _____
(Office Use Only)

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: _____

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 payment 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

 Name of Authorized Representative

 Relationship