Illinois
PAIN INSTITUTE

New Patient Form Packet

Instructions: Please bring your completed and signed forms to your first appointment. Additionally, pleased be sure to bring medical records, labs, imaging, insurance information, and other relevant materials.

Please call with any questions: (847) 289-8822

Illinois Pain Institute New Patient Locations

Elgin
431 Summit Street
Elgin, IL 60120-3861
Tel: (847) 289-8822
Fax: (847) 289-0815

Elmhurst
1200 S York Street
Suite 4250
Elmhurst Illinois 60126
Tel: (630) 748-3300
Fax: (630) 250-4933

Huntley
10350 Haligus Road
Suite 210
Huntley, IL 60142
Tel: (815) 363-9595
Fax: (847) 289-0815

Itasca
650 East Devon Avenue
Suite 152
Itasca, Illinois 60143
Tel: (630) 748-3300
Fax: (630) 250-4933

Lake Barrington
22285 Pepper Road, Suite 302
Lake Barrington, IL 60010
Tel: (847) 852-2000
Fax: (847) 852-2600

Libertyville
755 S Milwaukee Ave
Suite 175
Libertyville, Illinois 60048
Tel: (847) 984-2500
Fax: (847) 984-2503

McHenry
4309 Medical Center Drive
Suite B103
McHenry, IL 60050
Tel: (815) 363-9595
Fax: (815) 578-4530

Note: This packet contains 11 pages (including this cover page)

Intake /date: _____

Initials: _____

Illinois Pain Institute™

Appt: _____

Location: _____

Doctor: _____

New Patient Information

Patient Name_____ Home Phone _____

Address_____ City_____ State_____ Zip_____

SS#_____ Date of Birth_____ Sex: F Marital Status Widowed

Employer_____ Work Phone_____

Email:_____

▪Referring Doctor_____ Phone _____ Fax_____

▪PCP_____Phone_____Fax_____

▪Pharmacy_____Phone_____Fax_____

Auto ☐ Work Comp ☐ Other_____ DOI_____ Approved DX_____

POLICY HOLDER_____Relation_____

DOB_____ SS#_____ Address_____

City_____ State_____ Zip_____

PRIMARY INSURANCE_____Phone_____

Address_____City_____ST_____Zip_____

Group#_____ID_____Fax_____

PPO ☑ HMO ☐ EPO ☐ POS ☐ INDEM ☐

REF N Copay $_____ Effective Date_____ Verified With _____ Date_____

SECONDARY INSURANCE_____ Phone_____

WORK COMP ☐ AUTO ☑ PI ☐

Insurance Carrier_____ Phone_____

Address_____ City_____ State____ Zip_____

Claim # _____ Adjustor_____ Date_____

Attorney Name_____ Phone_____ Verified by_____

Address_____ City_____ State_____ Zip_____

ER Contact_____ Phone_____

Allergies_____

Med Records: Patient will bring ☑ MD to fax / mail ☐ Other information:_____

Illinois Pain Institute™

Intake Information

_____ _____ _____ Male ☐ Female ☐ Date _____
Last Name First Name Age

List Doctors you have seen & City

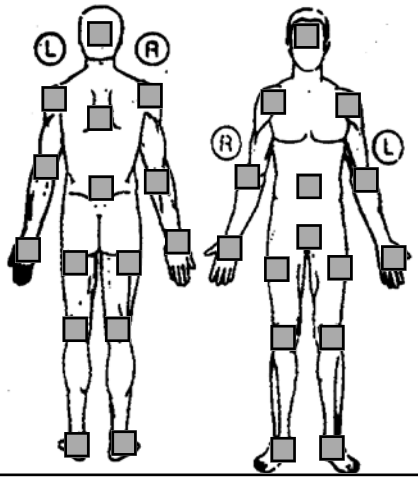
_____

_____

Circle words that describe your pain

Burning ☐ Stabbing ☐ Depressing ☐ Constant Freezing ☐
Hot Shooting ☐ Comes and goes ☐ Electric shock ☐ Dull Ache ☐
Tightness ☐ Unbearable ☐ Entire body throbbing ☐ Muscle Spasm ☐

Shade in where you have pain
Or describe in the box below



What started the pain?

_____

_____

_____

_____

Please describe any accidents you have had related to this pain:

_____

_____

What was the date of injury?: _____

What makes the pain better?: _____

_____

What makes the pain worse?: _____

_____

Pain Level: Place an X along this line to indicate how severe your pain is today.

No pain ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ Worst pain possible.
0 5 10

How many minutes can you walk until you must stop due to pain?: _____

What **specific activities** is the pain preventing you from doing?: _____

Please circle any of the following treatments you have had:

Physical Therapy ☐ Pool Therapy ☐ Biofeedback ☐ Tens Unit ☐ Acupuncture ☐ Nerve Blocks ☐
Trigger Point Injections ☐ Epidural Steroids ☐ Back Surgery ☐ Chiropractic Manipulation ☐
Psychological counseling for pain ☐ Other_____

Please list all **surgeries** you have had_____

_____

Are you working now? **Y** ☐ **N** ☐ What kind of work do you do?_____

What was your last date of work?_____ Is this a work related injury? **Y** ☐ **N** ☐

Was there ever a law suit regarding your pain? **Y** ☐ **N** ☐ Have you ever been on disability? **Y** ☐ **N** ☐

Your attorney's name_____

Address_____ Phone number_____

Illinois Pain Institute™

Intake Information

Who do you live with at home?_____

Are you: **Single** **Married** **Separated** **Divorced** **Widowed**

Please check any medical problems that you have had and the approximate year when you first had it. Place a check in the "Family" column next to it if one of your family members has or had the problem.

You	Family	Year		You	Family	Year	
☐	☐		Stomach problems	☐	☐		High blood pressure
☐	☐		Asthma/Bronchitis	☐	☐		Irregular heart beats
☐	☐		Depression	☐	☐		Heart disease/heart attack
☐	☐		Decreased appetite	☐	☐		Shortness of breath
☐	☐		Treatment by a Psychiatrist	☐	☐		Loud snoring
☐	☐		Cancer	☐	☐		Difficulty sleeping
☐	☐		Epilepsy	☐	☐		Pneumonia
☐	☐		Fainting spells	☐	☐		Headaches
☐	☐		Bleeding problems	☐	☐		Kidney problems
☐	☐		Emotional changes	☐	☐		Night sweats, fever
☐	☐		Decreased concentration	☐	☐		Weight loss or weight gain
☐	☐		Unexplained crying	☐	☐		Diabetes
☐	☐		Constipation	☐	☐		Numbness
☐	☐		Liver problems/yellow skin	☐	☐		Weakness
☐	☐		Stroke	☐	☐		Change in bowel, bladder or sexual function

Please list any other medical problems you have: _____

_____

Have you ever smoked? **Y** ☐ **N** ☐ What year did you stop?_____ Do you smoke now? How much?_____

Were you ever a heavy drinker of alcohol? **Y** ☐ **N** ☐ When did you stop?_____

How much do you drink now?_____

Have you ever used street drugs? **Y** ☐ **N** ☐ If so, please list:

Please circle if you have had any of the following:

TESTS	**Approx date:**	**Which Hospital:**
X-Ray:	_____	_____
MRI:	_____	_____
CT-Scan:	_____	_____
Nerve test:	_____	_____

Are you allergic to any medication? Please list:

_____

Please list all medications you are taking (including over the counter such as Tylenol), **or** give your list to our staff to copy for your records.

_____

Medications used in past?
Any problems you had?

_____

Release of Confidential Information

I _____, hereby authorize _____to
(Name of patient or authorized agent) *(Name of physician)*

release to_____
(*Health care facility, physician, agency, etc)*

_____
(Street address, city, state, zip code)
the following information contained in the patient record of _____
(Patient name)

born_____, residing at _____
(Birth date) *(Street address, city, state, zip code)*

☐ The entire medical record, excluding mental health treatment, alcoholism treatment, and HIV acquired immune deficiency syndrome (AIDS) records.

☐ Mental Health Treatment Records

☐ Alcoholism Treatment Records

☐ Drug Abuse Treatment Records

☐ HIV/Acquired Immune Deficiency Syndrome (AIDS) Records

☐ Other_____

☐ Laboratory Reports

☐ X-ray Reports

☐ Operative Notes

The above information can be released during the following period of time: From: _____to_____

The purpose(s) of the authorization (are)_____

☐ I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above described information, I understand that it will not be disclosed, except as provided by law.

☐ I understand that the practice may not condition treatment on whether I sign this authorization except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.

☐ I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law.

☐ I understand that this authorization is valid until it expires, unless revoked before that.

☐ I understand that I may revoke this authorization at any time by giving written notice to the physician of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclose my health information. Written revocation must be sent to the physician's office. Absent such written revocation, this Authorization for Release of Confidential Health Information will terminate on _____.

Signed:_____ Date:_____

ILLINOIS PAIN INSTITUTE

HIPAA NOTICE OF PRIVACY PRACTICES ("NOTICE")

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. IT FURTHER DETAILS HOW YOU OR YOUR PERSONAL REPRESENTATIVE MAY GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

This Notice describes how our practice and our health care professionals, employees, volunteers, trainees and staff may use and disclose your medical information to carry out treatment, payment or health care operations and for other purposes that are described in this Notice. We understand that medical information about you and your health is personal and we are committed to protecting medical information about you. This Notice applies to all records of your care generated by this practice.

This Notice also describes your right to access and control your medical information. This information about you includes demographic information that may identify you and that relates to your past, present and future physical or mental health or condition and related health care services. Typically your medical information will include symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment.

We are required by law to protect the privacy of your medical information and to follow the terms of this Notice. We may change the terms of this Notice at any time. The new Notice will then be effective for all medical information that we maintain at that time and thereafter. We will provide you with any revised Notice if you request a revised copy be sent to you in the mail or if you ask for one when you are in the office.

I. Uses and Disclosures of Protected Health Information. Your medical information may be used and disclosed for purposes of treatment, payment and health care operations. The following are examples of different ways we use and disclose medical information. **These are examples only.**

(a) Treatment. We may use and disclose medical information about you to provide, coordinate, or manage your medical treatment or any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your medical information. For example, we could disclose your medical information to a home health agency that provides care to you. We may also disclose medical information to other physicians who may be treating you, such as a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your medical information to another physician or health care provider, such as a laboratory.

(b) Payment. We may use and disclose medical information about you to obtain payment for the treatment and services you receive from us. For example, we may need to provide your health insurance plan information about your treatment plan so that they can make a determination of eligibility or to obtain prior approval for planned treatment, such as disclosing relevant medical information to the health plan to obtain approval for hospital admission.

(c) Healthcare Operations. We may use or disclose medical information about you in order to support the business activities of our practice. These activities include, but are not limited to, reviewing our treatment of you, employee performance reviews, training of medical students, licensing, marketing and fundraising activities and conducting or arranging for other business activities. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your medical information to remind you of your next appointment. We may share your medical information with third party "business associates" that perform activities on our behalf, such as billing or transcription for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your medical information, we will have a written contract that contains terms that asks the "business associate" to protect the privacy of your medical information. We may use or disclose your medical information to provide you with information about treatment alternatives, case management or other health-related benefits and services that may be of interest to you. We may also use and disclose your medical information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer, or a prescription refill reminder may be sent to you for a prescription you are currently prescribed or its generic equivalent. We may also send you information about products or services that we believe may be beneficial to you. You may contact **our Privacy Contact** to request that these materials not be sent to you. We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our **Privacy Contact** to request that these fundraising materials not be sent to you.

(d) Health Information Exchange. We, along with certain other health care providers and practice groups in the area, may participate in a health information exchange ("Exchange"). An Exchange facilitates electronic sharing and exchange of medical and other individually identifiable health information regarding patients among health care providers that participate in the Exchange. Through the Exchange, we may electronically disclose demographic, medical, billing and other health-related information about you to other health care providers that participate in the Exchange and request such information for purposes of facilitating or providing treatment, payment or health care operations.

II. Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object. We may use and disclose your medical information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your medical information. If you are not present or able to agree or object to the use or disclosure of the medical information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the medical information that is relevant to your health care will be disclosed.

(a) Others Involved in Your Healthcare. Unless you object, we may disclose to a member of your family, a relative or close friend your medical information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information if we determine that it is in your best interest based on our professional judgment. We may use or disclose medical information to notify or assist in notifying a family member or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your medical information to an entity assisting in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

(b) Emergencies. We may use or disclose your medical information for emergency treatment. If this happens, we shall try to obtain your consent as soon as reasonable after the delivery of treatment. If the practice is required by law to treat you and has attempted to obtain your consent but is unable to do so, the practice may still use or disclose your medical information to treat you.

(c) Communication Barriers. We may use and disclose your medical information if the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and, in our professional judgment, you intended to consent to use or disclosure under the circumstances.

III. Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object. We may use or disclose your medical information in the following situations without your consent or authorization. These situations include:

(a) Required By Law. We may use or disclose your medical information when federal, state or local law requires disclosure. You will be notified of any such uses or disclosure.

(b) Public Health. We may disclose your medical information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. This disclosure will be made for the purpose of controlling disease, injury or disability.

(c) Communicable Diseases. We may disclose your medical information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

(d) Health Oversight. We may disclose medical information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections and licensure. These activities are necessary for the government agencies to oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

(e) Abuse or Neglect. We may disclose your medical information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your medical information to the governmental entity authorized to receive such information if we believe that you have been a victim of abuse, neglect or domestic violence as is consistent with the requirements of applicable federal and state laws.

(f) Food and Drug Administration. We may disclose your medical information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

(g) Legal Proceedings. We may disclose medical information in the course of any judicial or administrative proceeding, when required by a court order or administrative tribunal, and in certain conditions in response to a subpoena, discovery request or other lawful process.

(h) Law Enforcement. We may disclose medical information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include: (i) responding to a court order, subpoena, warrant, summons or otherwise required by law; (ii) identifying or locating a suspect, fugitive, material witness or missing person; (iii) pertaining to victims of a crime; (iv) suspecting that death has occurred as a result of criminal conduct; (v) in the event that a crime occurs on the premises of the practice; and (vi) responding to a medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

(i) Coroners, Funeral Directors, and Organ Donors. We may disclose medical information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose medical information to funeral directors as necessary to carry out their duties.

(j) Research. We may use and disclose your medical information for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when an Internal Review Board ("IRB") or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate, written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

(k) Criminal Activity. Consistent with applicable federal and state laws, we may disclose your medical information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose medical information if it is necessary for law enforcement authorities to identify or apprehend an individual.

(l) Organ and Tissue Donation. If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

(m) Military Activity and National Security. If you are a member of the armed forces, we may use or disclose medical information, (i) as required by military command authorities; (ii) for the purpose of determining by the Department of Veterans Affairs of your eligibility for benefits; or (iii) for foreign military personnel to the appropriate foreign military authority. We may also disclose your medical information to authorized federal officials for conducting national security and intelligence activities, including for the protective services to the President or others legally authorized.

(n) Workers' Compensation. We may disclose your medical information as authorized to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illness.

(o) Inmates. We may use or disclose your medical information if you are an inmate of a correctional facility and our practice created or received your health information in the course of providing care to you.

(p) Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500, et seq. seq.

IV. The Following Is a Statement of Your Rights with Respect to Your Medical Information and a Brief Description of How You May Exercise These Rights.

(a) You have the right to inspect and copy your medical information. This means you may inspect and obtain a copy of medical information about you that has originated in our practice. We may charge you a reasonable fee for copying and mailing records. To the extent we maintain any portion of your PHI in electronic format, you have the right to receive such PHI from us in an electronic format. We will charge no more than actual labor cost to provide you electronic versions of your PHI that we maintain in electronic format. After you have made a written request to our Privacy Contact at the following address: 431 Summit St., Elgin, IL 60120, we will have thirty (30) days to satisfy your request. If we deny your request to inspect or copy your medical information, we will provide you with a written explanation of the denial. You may not have a right to inspect or copy psychotherapy notes. In some circumstances, you may have a right to have the decision to deny you access reviewed. Please contact the Privacy Contact if you have any questions about access to your medical record.

(b) You have the right to request a restriction of your medical information. You may ask us not to use or disclose part of your medical information for the purposes of treatment, payment or healthcare operations. You may also request that part of your medical information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice. You must state in writing the specific restriction requested and to whom you want the restriction to apply. You have the right to restrict information sent to your health plan or insurer for products or services that you paid for solely out-of-pocket and for which no claim was made to your health plan or insurer.

(c) We are not required to agree to your request. If we believe it is in your best interest to permit use and disclosure of your medical information, your medical information will not be restricted; provided, however, we must agree to your request to restrict disclosure of your medical information if: (i) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and (ii) the information pertains solely to a health care item or service for which you (and not your health plan) have paid

us in full. If we do agree to the requested restriction, we may not use or disclose your medical information in violation of that restriction unless it is needed to provide emergency treatment. Your written request must be specific as to what information you want to limit and to whom you want the limits to apply. The request should be sent, in writing, to our Privacy Contact.

(d) You have the right to request to receive confidential communications from us at a location other than your primary address. We will try to accommodate reasonable requests. Please make this request in writing to our Privacy Contact.

(e) You may have the right to have us amend your medical information. If you feel that medical information we have about you is incorrect or incomplete, you may request we amend the information. If you wish to request an amendment to your medical information, please contact our Privacy Contact, in writing to request our form *Request to Amend Health Information.* In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us.

(f) You have the right to receive an accounting of disclosures we have made, if any, of your medical information. This applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice. It excludes disclosures we may have made to you, family members or friends involved in your care, or for notification purposes. To receive information regarding disclosures made for a specific time period no longer than six (6) years and after April 14, 2003, please submit your request in writing to our Privacy Contact. We will notify you in writing of the cost involved in preparing this list. To the extent we maintain your PHI in electronic format, you may request an accounting of all electronic disclosures of your PHI for treatment, payment, or healthcare operations for the preceding three (3) years prior to such request.

(g) Uses and Disclosures of Protected Health Information Based upon Your Written Authorization. Other uses and disclosures of your medical information not covered by this Notice or required by law will be made only with your written authorization. For example, the following uses and disclosures require your authorization: (1) Most uses and disclosures of psychotherapy notes; (2) Uses and disclosures of PHI for marketing purposes unless (i) the communication occurs face-to-face; (ii) consists of marketing gifts of nominal value; (iii) is regarding a prescription refill reminder that is for a prescription currently prescribed or a generic equivalent; (iv) is for treatment pertaining to existing condition(s)and we do not receive any financial remuneration in either cash or cash equivalent; and/or (v) communication from us to recommend or direct alternative treatments, therapies, healthcare providers or settings of care when we do not receive any financial remuneration for making the communication; and (3) Disclosures that constitute a sale of PHI and other than those described in this Notice, require authorization. You may revoke this authorization at any time, except to the extent that our practice has taken an action in reliance on the use or disclosure indicated in the prior authorization.

(h) Right to be Notified of a Breach. You have the right to be notified in the event that our practice (or a Business Associate of ours) discovers a breach of unsecured protected health information.

(i) Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by obtaining a *Complaint Form* from our Privacy Contact. All complaints must be in writing. We will not retaliate against you for filing a complaint.

(j) To Contact Us: You may contact us by through our Privacy Contact as follows:

Illinois Pain Institute
Attn: Privacy/Compliance Officer
431 Summit Street
Elgin, Illinois 60120
847/289-8822 (telephone) 847/289-0815 (facsimile)

By signing this form, you acknowledge receiving this Notice and that you were afforded an opportunity to ask questions related to the content herein.

Signature of Patient _____ Date_____

Print Name of Patient _____

ILLINOIS PAIN INSTITUTE.

Patient Consent for Use and Disclosure of Protected Health Information (PHI)

I consent that Illinois Pain Institute may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Illinois Pain Institute "Notice of Privacy Practices (NPP) " for a more complete description of such uses and disclosures.

I have the right to review the NPP prior to signing this consent. Illinois Pain Institute reserves the right to revise its NPP at any time. A revised NPP may be obtained by forwarding a written request to Illinois Pain Institute, 431 Summit Street, Elgin, IL 60120 (Attn: Privacy/Compliance Officer).

I consent that Illinois Pain Institute may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminder, insurance items and any call pertaining to my clinical care, including laboratory results among others.

I consent that Illinois Pain Institute may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I consent that Illinois Pain Institute may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. I have the right to request that Illinois Pain Institute restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Illinois Pain Institute's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Illinois Pain Institute may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Patient's Name Date

_____
Print Name of Patient or Legal Guardian

_____ _____
Witnessed Date

9/2013

ILLINOIS PAIN INSTITUTE
ASSIGNMENT OF INSURANCE BENEFITS AND STATEMENT OF SERVICE

I hereby assign and authorize payment to Illinois Pain Institute of the covered insurance benefits, including major medical benefits, whether payable to me by BlueCross/Blueshield, Medicare, Medigap, worker's compensation carrier, and/or commercial insurance companies. I fully understand that I am financially responsible for and agree to pay all charges not paid by my health coverage, including deductibles, co-insurance and payments from insurance companies sent directly to me. In consideration of the medical service furnished to me, I herby agree to pay Illinois Pain Institute any balance due. If my account should become delinquent and collection efforts become necessary, I agree to pay any reasonable collection or attorney's fees incurred.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and /or employee health care plan with respect of medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law for to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and /or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and /or employee health care plan in my name but at such doctor and clinic's expense.

Should this assignment be prohibited in part or in whole under any anti-assignment provision of my policy/plan, please advise and disclose to my provider in writing such anti-assignment provision within 30 days upon receipt of my assignment, otherwise this assignment should be reasonable expected to be effective and such anti-assignment is waived.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement. This assignment shall apply to all services now rendered and to be rendered in the future until it is revoked.

I have disclosed the names of all my health insurance providers including tie-in-coverage, and I represent that such health care coverage is in full force and effect at this time. If prior authorization or certification for medical services is required under my health care coverage, I agree to obtain and furnish such authorization or certification.

I authorize the release of medical information as may be required to process the claims for payment of the medical service rendered, which may include medical records pertaining to mental health and /or substance abuse. Any account not paid in full by 45 days after the date it becomes patient responsibility, will be assessed a $10.00 rebilling fee for each month that the balance remains unpaid..

MISSED APPOINTMENT/PROCEDURES
Unless cancelled at least 48 hours in advance, we may charge you $50.00. For any procedure not canceled at least 48 hours in advance, we may charge you $100.00. Please help us serve you better by keeping your scheduled appointments.

PRESCRIPTION REFILL POLICY
Prescription refills will only be made at the time of your visit.

I have had an opportunity to discuss with the physician or his staff, to my satisfaction, the nature of the services provided. I acknowledge that no guarantees have been made to me as to the results.

I am satisfied that I fully understand this agreement and assignment and its significance.

I agree to promptly notify your office of any changes of address or change of health insurance providers or changes of worker's compensation carrier.
A copy of this assignment shall be considered as valid as original.

X_____
Patient Name Printed

X_____ X_____
Signature of Patient Signature of Insured(If Applicable)

X_____ X_____
Date Date

Social Security#_____ Social Security#_____

Employer_____ Employer_____

Insurance Co._____ Insurance Co._____
(Primary) (Secondary)

SIGN BELOW IF YOU HAVE MEDIGAP INSURANCE POLICY
MEDICARE LIFETIME MEDIGAP ASSIGNMENT

I assign and authorize payment of Medigap benefits to Illinois Pain Institute for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agency any information needed to determine these benefits payable for related services.

X_____ Date_____

01.04.16

Medigap Company_____