Name:
Chart:
Date:

ILLINOIS BONE & JOINT INSTITUTE®
Move better. Live better.

Thank you for choosing Illinois Bone and Joint Institute.
To assist us in providing excellent service, please **provide the information requested below.**

Office use only: MR #: ID verified:

1. Patient information:

Date:_____

Last Name	First Name (Legal)	M.I.
Street		
City	State	Zip
Cell	Home	Work

How would you like to be contacted: ☐ Home ☐ Cell ☐ Work ☐ Email ☐ Mail

I understand that if information is emailed to me, there may be some level of risk that this information could be read by an unauthorized party and am accepting these risks. Additionally, by providing my contact information I am authorizing IBJI, its physicians and staff to communicate with me electronically about my care, account, IBJI service surveys, IBJI products and services, and/or education.

Email Address:	Birth Date	Gender	Marital Status

Employer ☐ Retired — Occupation (include before retirement, if applicable)

Employer Address: — City

State — Zip — Employer Phone

Is your injury due to: ☐ Work accident ☐ Auto accident ☐ 3rd Party Liability (e.g.: claim against another party)

In compliance with IBJI's participation in a government program on patient quality of care we ask that you provide the following information (please note that you have the option to decline to answer these questions.

Race: ☐ African-American ☐ American Indian ☐ Asian ☐ Caucasian ☐ Native Hawaiian ☐ Unknown

Preferred Language:

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

2. Your health insurance:

Primary Insurance Company Name	Phone:
Policy Holders Name:	Birthdate: ____ ____ _____ MO DAY YEAR
Relationship To Patient:	
Insured's Employer:	Phone:
Secondary Insurance Company Name	Phone:
Insured's Name:	Birth Date: ____ ____ _____ MO DAY YEAR
Relationship To Patient:	
Insured's Employer:	Phone:

Name:
Chart:
Date:

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3. How did you hear about us?

Please <u>circle</u> as appropriate:

Referral:	**Media:**	**Other:**	
Athletic Trainer	Chicago Tribune	Direct Mail	Community Event
Friend/Family	Community Newspaper	Email	Emergency Room
IBJI Employee	Magazine	IBJI Website	Immediate Care
Other Patient	News Article	Internet search	Insurance Company
Physical Therapy	Radio / TV	Other	Professional Sports Event
Referring MD	Sign/Billboard		

Have you previously been treated by any IBJI physician ☐ No ☐ 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.
☐ 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.
☐ 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

Name:
Chart:
Date:

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Health Care Consent/Personal Belongings/NPP Acknowledgment/Phone Messages Authorization/Authorized Representatives

Patient Name: _____ **MR #** _____ **Date of Birth**: _____

Consent to Evaluate/Treat: I, for myself, or the patient named above, hereby consent to such medical evaluation (e.g. impairment rating, IME) 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 healthcare provider, ask questions regarding such treatment options and understand the options discussed. I understand there may be additional risks associated with COVID-19 as well as any public health emergency. I further understand IBJI has implemented employee and patient safety protocols to reduce the risk of spreading COVID-19, and I agree to notify staff prior to any appointment of any fever, symptoms or exposure. Initial box that you consent to medical treatment by IBJI.

Initial box that you consent to medical treatment by IBJI. ☐

The Notice of Privacy Practice (NPP) tells you how we may 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 for your treatment purposes.
- We will use and share your health records to run our business.
- We will use and share your health records as required/allowed 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. By initialing here, **I acknowledge receipt of the IBJI Notice of Privacy Practices.** ☐

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.

Initial box that you assume full responsibility for your personal property: ☐

Phone Message/Contact Authorization: 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?**

At home	_____ **Yes**	_____ **No ***
At work	_____ **Yes**	_____ **No ***
On cell	_____ **Yes**	_____ **No ***

*** IF YOU CHECK "NO", THE DATE, TIME AND LOCATION OF APPOINTMENTS WILL BE LEFT ON YOUR ANSWERING MACHINE.**

Authorized Representatives: The individual(s) named below will also be your emergency contact(s) unless you specify otherwise. 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)	_____	_____	_____

I understand that it is my responsibility to inform IBJI of any desired changes in this authorization.
Note: This consent/authorization expires one year after the date of signature.

Signature of Patient: _____ Date: _____

Signature of Authorized Representative: _____ Date: _____

Authorized Representative Name Printed: _____

Relationship of Authorized Representative: _____

Name:
Chart:
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.
- If you would like us to bill your insurance directly, we MUST HAVE A COPY OF THE CURRENT INSURANCE ID CARD otherwise you will be billed.
- 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.
- If you're here for a workers' compensation or accident claim, we will need your health insurance information and will bill that insurance if we do not receive proper documentation and/or payment from the workers' compensation or accident insurance carrier.
- 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.

Cancellation and No-Show Policy: If you wish to change or cancel an appointment, we ask that you please provide 24-hour advance notice. This allows us to offer your appointment to another patient who may be waiting to see a physician. We understand, however, that emergencies can and do happen, and will make every attempt to work with you. If you can't contact us 24 hours in advance, please call as soon as you know you cannot make your scheduled appointment. If you miss your appointment without notice or provide less than 24-hour advance notice, it will be considered a no-show. We may charge you a $25 fee for no-show. Patients who repeatedly no-show may be dismissed from the practice.

_____ _____
Patient Signature Date

_____ _____
Print Name/Signature of Authorized Representative/Relationship Date