PATIENT INFORMATION

NAME (Last, First, Middle Initial): ____

Sex: M / F Marital Status: S / M / W / D / P Date of Birth ________________Social Security # ______________________

Home Address___________________________________ Apt# ________ City _____________________State_____ Zip_________

Home Phone _______________________Cell Phone________________________ Work Phone______________________________

Email Address ____

Emergency Contact __________________________________ Relationship ___________________ Phone:___________________

Employer ____ Address_______________________________________

REFERRED BY: Circle One (Attorney / Insurance / Friend / School / Primary Care Physician)

Name ____ Phone #_______________________________________

Address____ City ____________________State ______Zip________

Part(s) of Body injured ____ **Date of Onset** _____/_______/_________

Is injury/condition related to: Work / School / Auto accident / Other____

Do you have an attorney for this injury? YES / NO If yes: Name of attorney____

Address ______________________________City ________________ZIP_______ Phone___________________________________

PRIMARY INSURANCE INFORMATION

Policy holder's name_________________________________ Policy holder's date of birth__________________________________

Policy holder's SSN _________________________________ Policy holder's relation to patient ____________________________

Employer____ Insurance Company ____

Ins. Co. Address________________________City _____________St _________ ZIP__________ Phone # _____________________

ID#_____________________________ Group/Policy #___________________ Referral required? YES / NO Copay: $________

SECONDARY INSURANCE/WORKERS COMP Please specify: Auto / Workers Comp / Homeowner or Liability

Insurance Company ____Claim #____________________________________

Address ____City__________________________St__________Zip_______________

Claims Adjustor ___________________________________Phone #______________________Ext________Fax#________________

I CONSENT TO MEDICAL TREATMENT BY THE CENTER FOR ATHLETIC MEDICINE, LTD AND HEREBY AUTHORIZE THE CENTER FOR ATHLETIC MEDICINE, LTD TO RELEASE INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS. I HEREBY ASSIGN TO THE CENTER FOR ATHLETIC MEDICINE, LTD ALL PAYMEN FOR MEDICAL AND OR SURGICAL SERVICES RENDERED TO ME OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE. I AGREE TO PAY ALL COSTS OF COLLECTION, INCLUDING REASONABLE ATTORNEY'S FEES, SHOULD THIS ACCOUNT BE PLACED WITH FOR COLLECTION.

SIGNATURE____ DATE __________________________

Center for Athletic Medicine LTD

Date: _____/_____/_____

Patient: ___________________________

Employer: ________________________

Claim/Group: ______________________

SS# / ID#: _________________________

I hereby instruct and direct _________________________________Insurance Company to pay by check, made out and mailed to:

Center for Athletic Medicine, LTD
P.O. Box 73569
Chicago, IL 60670

If my current policy prohibits direct payment to the Center for Athletic Medicine, LTD. I hereby also instruct and direct you to make the check to me and mail it as follows:

Center for Athletic Medicine, LTD
P.O. Box 73569
Chicago, IL 60670

For the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the 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 that is mentioned (assignee), and I have agreed to pay, in current manor, any balances of said professional service charges over and above this insurance payment.

A photocopy of this assignment shall be considered 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.

I also authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

________________________________	________________________________
Signature of Policy Holder	Witness
________________________________	______/_____/_____
Signature of Claimant/other than policy holder	Date

CENTER FOR ATHLETIC MEDICINE, LTD **MEDICAL HISTORY QUESTIONNAIRE**

NAME: ______________________________ **DATE:** _______/_______/_______

Date of Birth: _______/_______/_______ **Height:** ________________ **Weight:** ________________

CURRENT MEDICATIONS: please list all medications you are currently taking or have taken in the past month.

Name________________________ Dosage ____________Frequency____________

Name________________________ Dosage ____________Frequency____________

Name________________________ Dosage ____________Frequency____________

ALLERGIES	**Yes**	**No**		**Yes**	**No**		**Yes**	**No**
Any food allergy…………….……..	□	□	Inhalation allergy……..……	□	□	Adhesive tape allergy…………..	□	□
Any medication allergy…………….	□	□	Any skin allergy……..……	□	□	Latex allergy…………..………..	□	□

If there are any foods or medication allergies please list what they are: ______________________________

Any Anesthesia Allergy: **Yes** **No**

PAST SURGERIES/ILLNESSES/ACCIDENTS AND HOSPITALIZATIONS: **NONE** □ - Or list any hospitalization, accident, serious illness or past surgeries with approximate year at which performed (include minor surgeries such as tonsillectomy, tumors, etc.)

____

____ (continue on reverse side)

FAMILY HISTORY: If any of the following have run in your family, please check

FATHER:	Allergies □	Cancer □	Tuberculosis □	Diabetes □	Heart Disease □	Strokes □
MOTHER:	Allergies □	Cancer □	Tuberculosis □	Diabetes □	Heart Disease □	Strokes □

PATIENT HISTORY	**Yes**	**No**		**Yes**	**No**		**Yes**	**No**
HEAD AND NECK								
Severe headaches ……………………...	□	□	Double vision ……………............	□	□	Swelling in neck ………………. .	□	□
Dizzy spells………………………………	□	□	Discharge from ear …………...….	□	□	Fainting…………………………	□	□
Failing vision ……………………………	□	□	Prolonged hoarseness ……..…...…	□	□	Stroke ………………..………..	□	□
HEART AND LUNGS			High blood pressure…………...…..	□	□	Tuberculosis ……………………..	□	□
Chest pain……………………………...	□	□	Difficult breathing……………..….	□	□	Spit up blood ……………………	□	□
Heart attack...	□	□	Pneumonia ……………………..…	□	□	Ankles swell …………………….	□	□
Skipping heart beats…………………...	□	□	Chronic cough …………………...	□	□	Any heart defects/murmur ……….	□	□
STOMACH AND INTESTINES			Diabetes………………………….	□	□	Ulcers…………………………...	□	□
Persistent nausea…………………………	□	□	Skin turn yellow………………….	□	□	Blood from rectum ……………...	□	□
Heartburn regularly…………………….	□	□	Any chronic diarrhea……………..	□	□	Habitual constipation…………...	□	□
Appetite loss…………………………….	□	□	Any black stools…………………	□	□	Have hemorrhoids ………............	□	□
URINARY TRACT-ETC						(WOMEN ONLY)		
Any excess urination……………………...	□	□	Any leakage ……………..……..…	□	□	Painful menstruation …………….	□	□
Difficult urination ……………………...	□	□	Passed any stones ……………….	□	□	Excess menstruation ………….....	□	□
Any blood in urine………………………..	□	□	Any retention of urine……………..	□	□	Bleeding between periods …….…...	□	□
Excess night urination……………………..	□	□				Any missed periods ……………….	□	□
MUSCLES – JOINTS – NERVES	**Yes**	**No**		**Yes**	**No**		**Yes**	**No**
Any tingling sensations …………………..	□	□	Nervous breakdown……..………	□	□	Speech disturbances……….….....	□	□
Any Numbness……………………………	□	□	Any memory loss……….………	□	□	Any seizures ………………….....	□	□
Disturbance in walking …………………...	□	□	Personality changes ...……..……	□	□	Any emotional problems ……..….	□	□
Any muscle jerking ……………………...	□	□	Any Paralysis …………….……	□	□	Varicose veins ………….……….	□	□

Which Body Part are you here for today? ________________ Right _____ Left______How long? Months____Years______

Have you or a family member had a history of a blood clot? ____________ If "yes", please explain________________

Do you smoke or have you been a smoker? ______________ If "yes", describe type, amount and duration of smoking habit ______________

Do you drink? ________________ If "yes", indicate amount and frequency ________________

Have you ever been addicted or habituated to drugs or alcohol? ______ If "yes", please explain ________________

Are you on a special diet or do you restrict your diet in any way? _________ If "yes", please explain ________________

Other medical problems not listed: ______________________________

Are you currently under the care of another physician for any of the above conditions? Yes □ No □

Patient Signature____________________Date ____________Provider Init__________Date__________

Center for Athletic Medicine, Ltd.
830 W. Diversey Parkway, Suite 300
Chicago, IL 60614

The Center for Athletic Medicine, Ltd. (CAM) is providing a financial policy to all patients to avoid any misunderstanding or disagreement concerning payment for professional services. Prompt payment allows us to control costs. Outstanding accounts cost both of us time and money; therefore, all patients will be required to establish financial arrangements for payment on their account.

INSURED PATIENTS: our billing staff will submit the claims to your insurance. The patient is responsible for any co-payments, co-insurance, deductible, or non-covered service not payable by your plan. *Please note there are far too many insurance companies to know every patient's benefit plan. To avoid any surprises know your insurance benefits before your first appointment.*

SELF-PAY PATIENTS: will be required to remit full payment to establish an account.

WORKERS' COMPENSATION/LEGAL CASES: Though you are not responsible for your medical bills prior to your case settling; IF you lose your case, or IF your case settles and your workers' compensation insurance does not pay your outstanding bills, OR if your attorney does not send us a payment directly from your settlement YOU will be responsible for the outstanding balance.

All patient accounts are due and payable within 30 days of services rendered.

Statements will be mailed monthly which is due payable within 30 days. If your payment is not received you will receive one other reminder. If you are unable to pay off your balance please contact your billing representative and a payment plan may be set-up. Any balances after 61 days of notice without a financial arrangement in place will be sent to collection.

Any changes on your account such as address, phone number, insurance, etc., should be brought to our attention as soon as possible to avoid any discrepancies with your account.

OFFICE CHARGES

Office appointments need to be cancelled with-in 24 hours of your scheduled appointment time, or a $50 failed appointment charge will be assessed to your account.

Scheduled surgeries need to be cancelled with-in 48 business hours of your scheduled surgery time, or a $1000 charge will be charged on your account.

A $25 service charge will be charged for any non-sufficient funds check in addition to the amount of the check presented.

________________________________ ________________

Patient/Parent/Guardian Signature Date

HIPAA Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Center for Athletic Medicine, LTD and its practitioners (collectively, "Provider") for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of Provider. In making disclosures of my protected heath information, I hereby authorize Provider to transmit my protected health information electronically.

I am authorizing disclosure of my protected health information to:______________________________

____

I understand that the Provider may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the authorization except that the Provider may condition the provision of research related treatment on my provision of an authorization for the use or disclosure of protected health information for such research. In addition, I understand that the Provider may condition the provision of health care to me that is solely for the purpose of creating protected health information for disclosure to a third party on my provision of an authorization for the disclosure of the protected health information to such third party.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of Provider. Provider is not required to agree to the restrictions that I may request. However, if Provider agrees to a restriction that I request, the restriction is binding on Provider.

I have the right to revoke this consent, in writing at any time, except to the extent that Provider has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or a healthcare clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

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 federal privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act. However, information regarding HIV/AIDS, genetic testing, mental health, substance abuse and alcoholism may not be disclosed by the person authorized herein to receive said information without my express written consent. If Provider, a health plan (e.g. insurer, HMO, etc.) or health care clearinghouse has requested the use or disclosure of the protected information, I will be given a copy of this signed authorization.

This authorization shall be in force and effect until ______________________ at which time this authorization to use or disclose this protected health information expires.

I understand that I have a right to review Provider's Notice of Privacy Practices prior to signing this document. Provider's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations is also provided in the waiting area and on Provider's website at www.athleticmed.com. This Notice of Privacy Practices also describes my rights and the Provider's duties with respect to my protected health information.

Provider reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of the privacy practices by accessing the Provider's website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

______________________________ ______________________________
Signature of Patient or Personal Representative | Name of Patient or Personal Representative

______________________________ ________/________/________
Description of Personal Representative's Authority | Date

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