Circle One: Married Single Divorced Widowed

Name: _____ Gender: Male Female DOB: _____

Address: _____ City/State/Zip Code: _____

Home Phone: _____Cell Phone: _____Preferred: Home or Cell

Email address (for billing): _____Twitter handle_____

Social Security#: _____ Driver's License _____

Employer: _____ Occupation: _____

Address: _____

How did you hear about us? _____

Emergency Contact: _____ Relationship: _____

Contact information: _____

Insurance Carrier: _____

Subscriber: _____ Subscriber DOB: _____

ID: _____ Group #:_____

Is this is an Auto Accident or Worker's Comp? _____

Date of Accident: _____ Claim #:_____

Problem Area: Neck Back Low Back Hand Wrist Elbow Shoulder Knee Ankle Other:_____

Illness date: _____ Type of Pain: Dull Ache Burning Numbness Pins Needles Stabbing

Be specific with what you're experiencing:

_____

_____

Medications: Date Started:_____Name :_____ Dosage:_____ Freq. :_____

Allergies- Types: _____Reactions:_____

Surgeries & Hospitalizations: Date: _____ Surgery: _____

Major Illnesses (Circle): diabetes depression hypertension Other_____ None

Family History: History Cause of Death

Mother:

Father:

Pat. Grandmother:

Pat. Grandfather:

Mat. Grandmother:

Mat. Grandfather:

Smoking Habits Y or N Alcohol Y or N Caffeine Y or N Drug use Y or N Exercise Habits Y or N

CONSENT TO CARE

A patient coming to the doctor gives him/ her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/ she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/ she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician.

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

I have read and understand the foregoing

_____ _____

Patient's Signature Date

X-ray Questionnaire: For women only

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: _____

☐ There is a possibility that I a may be pregnant at this time

☐ Yes, I am definitely pregnant

☐ No, I am definitely not pregnant at this time

☐ I request that x-ray films not be taken because

_____

_____

_____

_____

Date of last menstrual period: _____

Right to a Paper Copy of this Notice – You have the right to receive a paper copy of this Notice of Privacy Practices, even if you have agreed to receive this Notice electronically. You may request a paper copy of this Notice at any time.

Right to File a Complaint – You have the right to complain to the Practice or to the United States Secretary of Health and Human Services (as provided by the Privacy Rule) if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. To file a complaint with the United States Secretary of Health and Human Services, you may write to: Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, DC 20201. All complaints must be in writing.

To obtain more information about your privacy rights or if you have questions about your privacy rights you may contact the Practice's Privacy Officer as follows:

Name: **Nancy Petrone**

Address: 275 W. Higgins Rd. Hoffman Estates, IL 60169

Telephone No. (847) 885-8820

We encourage your feedback and we will not retaliate against you in any way for the filing of a complaint. The Practice reserves the right to change this Notice and make the revised Notice effective for all health information that we had at the time, and any information we create or receive in the future. We will distribute any revised Notice to you prior to implementation.

I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

Patient: _____ Date: _____

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

*Please only sign the 2 X's

PICA

PICA

CARRIER

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) ☐ YES ☐ NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

X SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

X SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

Community Health and Rehabilitation

FINANCIAL POLICY

As a courtesy to our patients, we offer the following billing options. Please initial the one that applies to you and sign at the bottom of the page. FOR YOUR PROTECTION, PLEASE CHECK YOUR INSURANCE MANUAL FOR BENEFITS.

Private Pay

_____ Cash fee discount given. NO INSURANCE FORMS GENERATED.

Group/Health

_____ I would like to assign my benefits to your office and have you submit my insurance claims for me. I will pay for initial services rendered and any co-payment for subsequent services. If my deductible has not been met, I will pay the full amount until it is met. I understand that if my insurance company does not pay the balance with 45 days of submission, I am responsible for the entire balance overdue.

Auto Accident/Personal Injury

_____ I was involved in an automobile accident/personal injury and would like to assign benefits to your office and have you submit all charges to my car insurance company for me. I have been informed that it is policy to have all charges submitted to the car insurance first and after the car insurance has been exhausted, my health insurance will then be billed for the remaining balance. I will sign all liens necessary to protect your office. I also understand that regardless of settlement, I am personally responsible for the entire balance. If for some unforeseen reason your office is not paid within 45 days of claim submission, I will personally pay the entire overdue balance.

Worker's Compensation

_____ I was involved in an injury at work. I will see to it that all appropriate paper work is filed by my employer (i.e. accident report, etc.). I understand that it is my right as an Illinois citizen to have any bills incurred as a result of a work related accident paid for. I will read the Illinois worker's compensation pamphlet to better understand my rights. If after 60 days my claim is not paid, I will personally pay the overdue balance. I understand that if this is the case, my rights may have been violated and I have the option to seek legal counsel.

Medicare

_____ I am a Medicare participant and will pay for services as they are rendered. I understand that your office does not accept assignment of benefits for Medicare but will submit all charges to Medicare for me. I will read and sign the blue Medicare pamphlet so that I understand what services are covered.

Medicare Supplement

_____ I have a Medicare supplement and would like to assign benefits to your office for Part A Medicare.

PPO/Preferred Provider Organization

_____ I belong to a PPO that your office participates with. I understand that I am responsible for whatever co-payment, deductible, and non-covered services that my plan has set forth. I will pay the co-payment, deductible, and non-covered services that I am responsible for, as laid out by my plan.

Maintenance Care

_____ I understand that maintenance care is not covered by some insurance companies. I will pay the maintenance fee as services are rendered and I understand that insurance will be billed for me.

This office is a unique practice in that we offer both chiropractic and physical therapy services. For every condition, we draw up a prescription for physical therapy that our office can oversee or that you may take to another office to have carried out. As a result of the above, we bill the insurance companies separately for physical therapy and chiropractic services. If your insurance policy excludes one of the above (i.e., chiropractic or physical therapy), please notify our staff in advance so we may try to maximize your coverage.

**CONTINUED ON THE BACK SIDE

If you are accepted as a patient you are expected to pay at the end of each visit unless other arrangements are approved.

This office will gladly prepare medical forms, but we cannot render services on the assumption that our charges will be paid by an insurance company. You are responsible for payment whether or not paid by insurance.

ASSIGNMENT OF BENEFITS AND POWER OF ATTORNEY TO CASH CHECKS
I, the undersigned, do hereby authorize payment directly to the office below, the benefits of my coverage, if any, otherwise payable to me for services but not to exceed the customary charge for those services. If these payments are made out to me I grant unto the office below as attorney the full power and authority in my name and stead of endorse any and all checks and drafts or money orders. I hereby authorize the doctor to release all information necessary to secure payment of benefits. A photocopy of this assignment shall be valid.

AUTO AND OTHER ACCIDENTS-NOTICE OF LIEN TO ATTORNEY
I hereby authorize and direct you, my attorney, to pay directly said doctor such sums as may be due and owing him for medical service rendered me both by reason of this accident and by reason of any other bills that are due to his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor. I hereby further give a Lien on my case to s aid doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I agree never to rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement, judgment, or verdict, as may be necessary to adequately protect said doctor above named. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded fees and costs.

In the event the bill is not paid and is turned over to our professional collected company. Certified Services, Inc., information will be given to the collection company and may include, but is not limited to: name, address, phone number, social security number, employment phone number.

THE PATIENT/PARENT AGREES TO ALL TERMS REGARDING THIS FINANCIAL POLICY.

Dated at: COMMUNITY HEALTH AND REHABILITATION
DATE: _____

_____
SIGNATURE OF INSURED/CLEMENT

_____
WITNESS