

Thank you for choosing Illinois Bone and Joint Institute. To assist us in providing excellent service, please provide the information requested below	Date: _____
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1. Patient information: Office use only: MR # _____ ID verified _____

Last Name	First Name (Legal)	M.I.
Street	City	
State	Zip	
Phone Home	Work	Cell
<i>Your email will only be used to communicate with you about your care, account, IBIJ service surveys, or education.</i>		Email Address:
SSN	DOB	Gender M F Marital Status
Employer	Occupation	
Employer Address:	City	
State	Zip	Employer Phone
Is your injury due to: <input type="checkbox"/> Work accident <input type="checkbox"/> Auto accident <input type="checkbox"/> 3 rd Party Liability (eg: claim against another party)		

2. 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

3. Emergency contact:

Name	Phone - Home
Relationship	Cell/Work/Pager

4. 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:

5. Your health insurance:

Primary Insurance Company Name:	Phone:
Policyholder's Name:	Birth-date: <u> </u> <u> </u> <u> </u> MO DAY YEAR
Medicare # or ID#:	Group #:
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
Medicare# or ID#:	Group #:
Relationship to Patient:	
Insured's Employer:	Phone:

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

Facility Name:	
Facility Address:	

THE INFORMATION PROVIDED ABOVE IS TRUE AND ACCURATE:

 Name of person completing this form

 Signature of person completing this form

 Relationship to Patient

 Date

Health Care Consent

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

CONSENT TO TREAT: I, for myself (or the patient named above), hereby consent to such medical 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

Print Name of Authorized Representative

Relationship to Patient

Notice of Privacy Practices Acknowledgement/Phone Message and Contact Authorization

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

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 to run our business.
- We will use and share your health records as required 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. **I acknowledge receipt of the IBJI Notice of Privacy Practices (NPP).**

Signature of Patient: _____ Date: _____

Signature of Authorized Representative: _____ Date: _____

Name of Authorized Representative: _____ Relationship: _____

Phone Message and Contact Authorization: Please CHECK the appropriate answer below:

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 ***

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

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)	_____	_____	_____
(3)	_____	_____	_____

I understand that it is my responsibility to inform IBJI of any desired changes in this authorization.

Note: This authorization expires one year after the date of signature.

Signature: _____ 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.
- ▶ 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