ID#_______

LOC______

PATIENT DEMOGRAPHIC FORM

DATE: _______________

NAME: ____
(First) (Last)

DATE OF BIRTH: _____________ SS#: _________________ EMAIL: ___________________________

ADDRESS: ____
(Street) (City) (State) (Zip)

SEX: M____ F____ MARITAL STATUS: MARRIED______ SINGLE_______ WIDOWED_______ DIVORCED_________

HOME TEL #: (_____) ____________ CELL #: (____)___________ CONTACT BY: CELL#________HOME#_______

REFERRED BY: (PLEASE CHECK ONE) PCP DR___REFERRING DR.___FRIEND___FAMILY__INTERNET__OTHER___

PCP-NAME: ____________________________TEL#: (_____) _______________ FAX#: (_____) ________________

REFERRING DR. NAME: ___________________TEL#: (_____) _______________FAX#: (_____) ________________

EMPLOYED BY: ____WORK#: (_____) ________________

EMPLOYER ADDRESS: ____TEL#: (_____) __________________

EMERGENCY CONTACT: ______________________________RELATIONSHIP: ___________TEL#: _______________

PRIMARY INSURANCE NAME: __________________________ HMO______PPO______

SUBSCRIBER: SELF______SPOUSE_____ SPOUSE NAME: _________________________DATE OF BIRTH: ___________

IF MINOR GUARANTOR NAME: ___________________________________RELATIONSHIP: _________________

POLICY/ID#: ____GROUP#: ______________________

SECONDARY INSURANCE NAME: _______________________HMO__PPO__ ID#: _______________________

INJURY RELATED TO: WORK____AUTO____ DATE OF INJURY: __________________

IF RELATED TO WORKMANS COMPENSATION PLEASE COMPLETE ADDITIONAL FORM PROVIDED

IF RELATED TO AUTO PLEASE PROVIDE HEALTH INSURANCE INFORMATION ONLY!

WORKMAN'S COMPENSATION INSURANCE COMPANY:

NAME: ___________________________________ADDRESS: ____

CLAIM#: _______________________ DATE OF INJURY: _____________ ADJUSTOR NAME: __________________

TEL#: (____) ___________________FAX#: _____________________________

ATTORNEY INFORMATION:

NAME: ___________________________________ ADDRESS: ____

TEL#: (____) _________________________

BY SIGNING BELOW, I CERTIFY ALL INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

PATIENT/GUARANTOR NAME IF MINOR(PRINT): ____

PATIENT SIGNATURE: ____DATE: ______________

VERIFIED BY: PSGC EMPLOYEE NAME: ______________________________________DATE: ______________

Patient ID:_________

Pain Specialists of Greater Chicago Receipt of Notice of Privacy Practices & Patient Information Authorization

I,____, hereby acknowledge receipt of the PSGC, S.C. Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved the right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or will be made available.

I authorize the methods of communication of my protected health information as indicated below. I understand that under the HIPAA guidelines my patient information is kept confidential unless I provide written authorization.

The following person(s) may inquire regarding a medical service or billing statement, pick up records and prescriptions, and take messages pertaining to my health information.

1. ____.Relationship ______________
2. ____Relationship ______________

I authorize PSGC to leave a message or send information regarding my personal health history, such as test results, physician messages, insurance or billing information or appointment information. Please initial each line that you authorize:

_____________ Telephone message
_____________ with a person listed above
_____________Mail to: Home or Office
_____________Fax to: Home or Office fax number: _____

____ _______________
Signature of Patient or Legal Guardian Date

____ _______________
Print Patient's Name Print Name of Legal Guardian (if applicable)

PAIN SPECIALISTS OF GREATER CHICAGO

7055 HIGH GROVE BLVD• SUITE 100 • BURR RIDGE, IL 60527

630-371-9980 .. 630-371-1555

PATIENT ID__________

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS FOR PAIN SPECIALISTS OF GREATER CHICAGO & CONSENT FOR TREATMENT:

I hereby authorize Pain Specialists of Greater Chicago and its employees and agents to release my medical records documenting my examination and treatment, for submitting claims and upon valid request to Insurance companies.

I hereby assign benefits for payments to be made directly to Pain Specialists of Greater Chicago by Insurance companies for any medical/surgical procedures performed. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

I agree to be financially responsible to Pain Specialists of Greater Chicago, for all charges in the event that I have no insurance or my insurance is rejected, and for any balance or fee not covered by my insurance and/or determined to be my responsibility.

I Understand and acknowledge that is Pain Specialist of Greater Chicago files my insurance claim, I will remain responsible for the account, and I will be expected to pay any amount due if my insurance does not pay the claim within 30 days.

I hereby request and authorize all doctors, nurses, technicians or affiliated medical personnel, hospitals and health care facilities to furnish all records and reports, including x-rays, photostatic copies, and abstracts or excerpts of all records, and any other information requested by Insurance companies relating to any hospitalizations, examinations, treatments, tests or opinions concerning any condition for which am presently being treated, including psychiatric or substance abuse information. A copy of this authorization shall be as valid as the original of this document.

GENERAL CONSENT TO TREATMENT

By signing below, (or my authorized representative on my behalf) authorize Pain Specialists of Greater Chicago, physicians. practitioners and their staff to conduct any diagnostic examinations, tests and procedures and to provide any medications, treatment or therapy necessary to effectively assess and maintain my health, and to assess, diagnose and treat my illness or injuries. In giving my general consent to treatment, understand that retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating health care

RIGHT TO REFUSE TREATMENT

I understand that it is the responsibility of my individual treating healthcare providers to explain to me the reasons for any particular diagnostic examination, test or procedure, the available treatment options and the common risks and anticipated burdens and benefits associated with these options.

PRINT PATIENT NAME:____

PATIENT (GUARANTOR) SIGNATURE:______________________________________ **DATE:**____________

Patient ID#__________

SIGNATURE SHEET

Initial Below

_____ 1) I have read and agree to Pain Specialists of Greater Chicago Notice of Privacy Practices/ IDPAA policy. Policy #1

_____ 2) I have read and agree to Pain Specialists of Greater Chicago Medication and Prescription/ Refill Policy. Policy #2

_____ 3) I have read and agree to Pain Specialists of Greater Chicago Controlled Substance to Treat Chronic Pain Policy. Policy #3

_____ 4) I have read and agree to Pain Specialists of Greater Chicago Consent to Treat with Opioids Policy. Policy #4

*I will be using the following pharmacy for my prescriptions:

Pharmacy Name ____________________________ Phone____________________

Signature____ Date__________

Print_____________________________ E-mail Address________________________

7055 High Grove Blvd. Ste. 100 Burr Ridge, IL 60527

REQUEST FOR RELEASE OF MEDICAL RECORDS

Patient Name: ______________________________ SS#. ______________

Address: ____

Date of Birth: ______________________ Phone: ____________________

I authorize the release of the following medical information to Pain Specialists of Greater Chicago:

Physician Notes	Radiology Imaging Reports
EKG/ EMG Reports	Admission/Discharge
Surgical Reports	Patient Insurance Information
Any & All	Other: ______________

Document Date: From __________ to __________

From: ____

Phone: ______________________ Fax: ______________________

Address. ____

Please Fax to: Medical Records
7055 High Grove Blvd Ste. 100
Burr Ridge, IL 60527
Phone 630-984-4799 Fax 877-295-7647

-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 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 subjected tore-disclosure 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: ______________

______________________ Pt. Signature ______________ Date

If the patient is a minor, subject to guardianship. I have signed my name below on behalf of the patient and myself.

______________________ Parent's, Legal Guardian's or Agents signature ______________ Date

rev9/17

Patient ID:____________

PAIN SPECIALISTS OF GREATER CHICAGO

BENEFIT ASSIGNMENT POLICY

Given the constant changes to insurance company payment policies, the following in-office policies have been established to help us continue to provide the patient with the best quality of medical care. These policies are intended to assist the patient in receiving care and for greater understanding in all aspects of patient care. If you would like to discuss these office policies, please ask to speak with a member of our Billing Department.

PAYMENT IS DUE AT THE TIME OF SERVICE.
This includes co-pays, deductibles, co-insurance and non-covered charges.

a) Co-pay must be paid at the time of visit.
b) For the patient's convenience, the office accepts cash, Visa, Master Card, Discover, and American Express-**NO CHECKS ACCEPTED**
c) The patient is responsible for-All NON-COVERED SERVICE CHARGES
d) **SELF PAY** patients must pay at time of visit-
ESTABLISHED PATIENT-Subsequent visit fees-**$100.00**, Lab Test Fees-**$127.00** Expected at next appointment
NEW PATIENT-$274.00 This includes the office visit fee of **$147.00** and Lab Test Fee of **$127.00.**

ANY CHANGES to your **DEMOGRAPHICS** or **INSURANCE** must be brought to our attention, **BEFORE** the Doctor's visit. Failure to do so may result in the patient being responsible in **FULL** for **ANY & ALL** charges for services rendered. The **CORRECT** information is **CRITICAL** especially for proper billing of laboratory tests that may be required and ordered. If this information is incorrect or not current the patient will be responsible for the bill in its entirety.
Health Insurance/Plan ID cards must be current.

If you have medical insurance, as a courtesy to you we will try to speed up the processing of your claim by submitting claims to your insurance company. However, your insurance plan is a contract between you and your insurance company. Our office **CANNOT** guarantee that your carrier will pay your claim. **If your claim is denied by your carrier, the obligation for payment is the responsibility of the patient.** Our office will **not** enter into a dispute with the insurance carrier over the claim. We will however, be happy to assist wherever possible. If the patients' bill remains overdue greater than 90 days the following procedure will occur.

- Any outstanding balance after **90** days of the date of service will become Zero balance status and **cannot** carry a balance.
- All outstanding bills must be settled **PRIOR** to receiving future care, unless **PRIOR** arrangements have been made.

Precertification for Procedures: Benefits verification/ Authorization contains general reimbursement information based on medical necessity and is not a guarantee of payment by my insurance company and is provided to me by PSGC- **By signing this form, I am fully responsible for any balance due to non-payment by my insurance company.**

Cancellations/Missed appointments - Failure to keep your appointment or failure to cancel your appointment within a **24-hour** notice to fill the time slot we have reserved for you will result in a penalty charge of **$50.00**, for an office visit and **$150.00** for procedures These fees are NOT covered by insurance and is the sole responsibility of the patient. You the patient will be billed and payment is expected before next appointment. Please have the courtesy and respect to call our office for all appointments that cannot be kept.
We work with you at every opportunity to provide you with the best quality health care.

I have read and understand the payment policy and agree to abide by its guidelines:

Print Name: ________________________________ **Date:** __________

Signature: ________________________________

Verified By PSGC Employee Name: ____________________ **Date:** __________

PATIENT AGREEMENT BETWEEN PAIN SPECIALISTS OF GREATER CHICAGO AND PATIENTS WHO ARE PRESCRIBED CONTROLLED SUBSTANCES TO TREAT CHRONIC PAIN

The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe these medications to you.

The long-term use of such substances as opioids (NARCOTIC pain medications), benzodiazepine tranquilizers, and barbiturate sedatives is controversial because it is not certain whether they are beneficial when used to treat chronic benign pain. Patients who are prescribed these drugs have some risk of developing an abusive relationship with the medication or suffering a relapse of a prior history of substance abuse. The extent of this risk is not certain. Additionally, these substances have a narrow therapeutic window and the risk of accidental over dosage and death is high.

Because of the risk that a patient may have a substance abuse disorder and because of the risk of diversion of these medications to those with substance abuse disorders it is necessary to observe strict rules when they are prescribed on a regular and continuous basis. For this reason we require each patient receiving long-term treatment with these medications to read, understand in full, and agree to the following policies.

It is agreed by you, the patient, as consideration for, and a condition of, the willingness of the physician whose signature appears below to consider prescribing or to continue prescribing controlled substances to treat your chronic pain.

1. All opioids used to treat my chronic pain must come from a provider in this office. My controlled substances will come from the caregiver whose signature appears below, or, during his or her absence, by another caregiver unless specific authorization is obtained for an exception. I will notify my providers of all medications used to treat other conditions prescribed by any other care providers.

2. I will not allow anyone else to have, use, sell, or otherwise have access to these medications

3. I will cooperate with unannounced urine or serum toxicology screens as may be requested. I understand that any evidence of tampering with these screens will affect my ability to be treated with controlled substances. I agree to come to office on the day I am called and will plan for this, including making sure I will have transportation.

4. I understand that my physician and his/her staff will access the Illinois Prescription Monitoring Program (ILPMP) database for purposes of verifying that I am complying with the controlled substances policies of this office.

5. I understand that my physician will perform criminal background checks for purposed of ensuring lack of diversion.

6. I agree to bring my unused medications to each office appointment, or when I am summoned to do so. I will be prepared for a pill count during a telehealth visit. I understand that if circumstances warrant it, a provider may call me in for a pill count. I understand that this must be accomplished as soon as possible after the phone call and at least by the end of the day that I am called. I understand that this is another risk mitigation technique and non-compliance will lead to a consequence.

7. I will comply with any monitoring or restrictions that my physician requires.

8. I will inform my physician/provider of any personal current or past substance abuse and any current or past substance abuse of any immediate member of my immediate family.

9. I will make an effort to obtain all controlled substances from the same pharmacy. Should the need arise to change pharmacies; I will inform the PSGC office. The pharmacy I am seeing is: _____

10. I will inform the PSGC office of any new medications or medical conditions, and of any adverse effects I experience from any of the medications that I take.

11. I agree that my prescribing providers have has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide my health care for purposes of maintaining accountability.

12. I understand that tampering with a written prescription is a felony and I will not change or tamper with my doctor's written prescription.

13. I will take my medication as prescribed and I will not exceed the maximum prescribed dose.

14. I understand that if I have medications left at the end of the month, I will notify the PSGC office so that my future prescriptions can be adjusted accordingly and so that the excess medications can be disposed of properly. I understand that I am not to "stockpile" my medications and that any excess medications or old prescriptions of controlled substances should be brought to the PSGC office for proper and documented disposal.

15. I understand that these drugs should not be stopped abruptly, as withdrawal syndromes will likely develop.

16. I understand that the presence of unauthorized substances, the lack of presence of prescribed controlled substances, or the presence of any illicit substances on urine toxicology testing will lead to a consequence depending on the level of non-compliance. This may prompt referral for assessment for a substance abuse disorder.

17. I understand that these drugs may be hazardous or lethal to other people and animals and that I must keep them secure.

18. I understand that medications may not be replaced if they are lost, damaged, or stolen. If any of these situations arise that cause me to request an early refill of my medication I will be required to complete a statement explaining the circumstances. At that time a determination will be made as to whether I may receive an early refill.

19. I understand that if I request an early refill secondary to lost, damaged or stolen prescriptions this will be considered a considered "red flag" and may lead to a consequence. -The consequences may include change or cessation of treatment with controlled substances, referral to an addiction specialist, urine testing and possibly discharge from the practice.

20. I understand that a prescription may be given early if the physician or the patient will be out of town or otherwise indisposed when the refill is due. These prescriptions will contain instructions to the pharmacist that the prescription(s) may not be filled prior to appropriate date.

21. If the responsible legal authorities have questions concerning my treatment, as may occur, for example if I obtained medication at several pharmacies, all confidentiality is waived and these authorities may be given full access to my full records of controlled substance administration.

22. I understand that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribing by this physician or referral for further specialty assessment.

23. I will make every effort to keep my scheduled appointments in order to receive medication renewals. I understand that regular and continuous monitoring is vital to my care and treatment while utilizing controlled substances and my failure to keep scheduled appointments may result in cessation of therapy with controlled substance prescribing by this physician.

24. I understand that no refills will be given at night or on weekends.

25. I understand that any medical treatment is initially a trial, and that continued treatment with opioid medications is contingent on whether my physician believes that the chosen treatment is improving my clinical status.

26. I have been explained the risks and potential benefits of these therapies, including, but not limited to psychological addiction, physical dependence, tolerance and withdrawal. I have been explained the risks of over dosage including the possibility of respiratory arrest and death. I understand that there is evidence of other risks as well including hormonal side effects and enhanced sensitivity to pain in some cases.

27. I affirm that I have full right and power to sign and be bound by this agreement, and that I have read, understand and accept all its terms.

28. I am aware that attempting to obtain a controlled substance under false pretenses is illegal. I am aware that this is a felony.

29. I understand that at no time am I to operate heavy machinery, including driving a car, while under the influence of these medications or any other medications that may alter my judgment. I understand that there is the possibility of severe civil or criminal penalties if this occurs.

I, ______________________________________, attest that I have carefully read the above policy and have asked questions about anything I did not understand.

Patient signature and date ____