Maximize Life Minimize Pain
PAIN SPECIALISTS
OF GREATER CHICAGO

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: _____

7055 HIGH GROVE BLVD, BURR RIDGE, IL 60527
P-(630)-371-9980 F-(630)-371-1555

Patient ID: _____

Maximize Life Minimize Pain

PAIN & REHAB SPECIALISTS OF GREATER CHICAGO

Authorization for Release of Confidential Health Information

Patient name: _____ Telephone: _____

Address: _____ Date of Birth: _____

City/State/Zip: _____

I hereby authorize the protected health Information regarding the above-named person to be exchanged to the following person(s) listed below:

Person/Institution/Other: _____

Phone #: _____

I authorize PSGC to release information concerning my health information listed below: I authorize that my information may be release in the form of all methods checked below.

- o Telephone
- o With a person listed above
- o Mail to: office or home
- o Fax to: Home/Office, Fax number: (_) _____

The following types of information to be disclosed are as follows:

- o Office Visit Notes
- o Operative Reports
- o History and Physical exam
- o Labs, X-rays, films
- o Picking up Records
- o Take messages concerning health information
- o Test Results
- o Insurance/Billing statements
- o Other: _____

The following Highly Confidential items must be checked off to be included in the disclosure:

- o Behavioral or mental health information/records (740 ILCS 110/1 et seq)
- o HIV/AIDS related information/records (410 ILCS 305/9)
- o Drug/alcohol diagnosis, treatment, referral Information (20 ILCS 301/30.5; 42 CFR pt. 2)
- o The release of information involving a direct or indirect payment to Pain Specialist of Greater Chicago S.C from a third party: for the sale of protected health information or for marketing.

This authorization release will expire 1 year after the date of your signature.

- I understand that I have the right to inspect and copy the information that I have authorized to be disclosed by this authorization. In the event that I refuse to authorize the release of the above-described information, I understand it will not be disclosed except as provided by law.
- I understand that the practice may not condition on whether I sign this authorization, except when the provision of healthcare is 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 subject to redisclosure by the recipient and may no longer be protected by law.
- I understand that this authorization is valid until expires, unless revoked before that.
- I have read and understood the terms of this Authorization and I have had the opportunity to ask questions about the use and disclosure of my health information. I have been provided a copy of the PSGC Notice of Privacy Practices. By my signature, I knowingly and voluntarily authorize Pain Specialist of Greater Chicago S.C to use of disclose my health information in the manner described above.

Please Contact our office immediately to make any changes to your HIPAA Form.

Printed name of patient, legal guardian, or authorized agent: _____

Signature of patient or legal guardian, or authorized agent: _____

Date: _____ Relationship to the patient: _____

Staff Initials: _____ Date: _____

Pain Specialist of Greater Chicago S.C

7055 High Grove Blvd Suite 100

Phone: 630-371-9980

Main Fax: 630-371-1555

Maximize Life Minimize Pain
PAIN SPECIALISTS
OF GREATER CHICAGO

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 to re-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*

PAIN SPECIALISTS OF GREATER CHICAGO

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:_____

PAIN SPECIALISTS OF GREATER CHICAGO

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

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

Patient ID#_____

PAIN SPECIALISTS OF GREATER CHICAGO

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_____

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: _____