PATIENT DEMOGRAPHICS:

Patient Name: _____

Date of Birth:_____ Sex: M F T Preferred Name:_____

Home Address:_____

City: _____ State:_____ Zip Code:_____

Email:_____

Primary Phone #:_____Cell #:_____

Is English your Primary Spoken Language? Yes No Language:_____

Emergency Contact Person:_____

Relationship to Patient:_____

Primary Phone #:_____Cell #:_____

If patient is UNDER 18 Parent/Guardian Name:_____

Parent/Guardian Phone #:_____ Guardian SSN #:_____

PRIMARY CARE DOCTOR:_____

Address:_____

Office Phone #:_____

REFERRING DOCTOR:_____

Address:_____

Office Phone #:_____

PHARMACY:_____

ADDRESS:_____

PHONE #:_____

Insurance – PLEASE FILL OUT IF THE PATIENT IS NOT THE POLICY HOLDER

Primary:_____

Policy holder's name:_____Policy holder's DOB:_____

Secondary:_____

Policy holder's name:_____Policy holder's DOB:_____

1675 S. Arlington Heights Road
Arlington Heights, IL 60005
PHONE: (847)255-0900
FAX: (847)255-4344

PATIENT INFORMATION- PLEASE PRINT

Please describe your current status by checking the appropriate category:

____ Working full-time ___ Military (active/reserve) ___ Retired (volunteer? Y N)

____ Working part-time ___ Not currently working (please list reason or cause)

____ Self Employed _____

My current or previous occupation is: _____

What is your marital status? Single Married Widowed Divorced Other_____

Do you live alone? Yes No If "No" with whom do you live? _____

_____

Have you had any of the following tests done within the last 3 years that are related to your pain?

X-Ray EMG CT Scan MRI Bone Scan Ultrasound Other_____

Where were these tests/procedures done? _____

Please describe the location of your pain: _____

_____

When did the pain first seem to be a problem? Check appropriate category.

Write date of when pain started: _____

___On-the-job injury date ____/____/_____ ___Car accident date _____/_____/_____

___Related to cancer date ____/____/_____ ___No exact date time when pain first began

Please use this section to provide other information on your pain including circumstances of how it started. It is also helpful to know what you feel makes the pain better or worse.

_____

_____

_____

_____

_____

_____

HEALTH HISTORY & FAMILY HISTORY

- Pease check any of the following conditions that YOU have or are a part of your IMMEDIATE family history.

__Depression __Neck/Back problems __Neck/back surgeries or operations __Chronic pain

__Fibromyalgia __Migraine Headaches __Arthritis or joint replacement Surgery __Cancer(any)

__Heart Disease __ Taking Blood Thinner __Pacemaker Stroke or Stent(date)_____

Do you have any other medical problems the doctor should know about? ____NO _____YES
If the answer is "YES" please, list the conditions you have been diagnosed or treated for in the past.

_____

_____

Have you ever had any surgeries or operations? (Even if it is unrelated to your pain) ____NO ____YES
If the answer is "YES" please, list all surgeries/operations performed and dates when they were performed.

_____

_____

Do you have any known allergies or sensitivities to any medications/drugs? ____NO ____YES

If "YES" list below:

_____

_____

What time do you go to bed? _____ How many hours of sleep do you get per night? _____

How would you rate how you sleep now? _____Poor _____Fair _____Good ____Very Good _____No Change

How would you rate your appetite now? _____Poor _____Fair _____Good _____Very Good _____No Change

Do you smoke? NO YES Packs per day_____ **Former smoker?** NO YES **When did you quit?** _____

Do you drink alcohol? ___Never ___ Rarely ___Socially ___Occasionally ___Daily ____ Recovering Alcoholic

Have you **EVER** had a history of any alcohol or drug abuse problems? ___NO ___YES

If "YES" please explain:

_____

_____

Is there any other family history you think we should be aware of? ___NO ___YES

If "YES" please explain:

_____

_____

If your condition is a result of an injury (work, auto, or personal injury) please complete the section below:

Date of injury ____ / ____ / ____ Did you receive compensation of any kind? ____NO ____YES

___Social Security Disability ___Welfare/Food Stamps ___Applied for disability - application pending

___Workers' Compensation ___Lawsuit pending settlement Other: _____

Employer: _____

Name of Employer Address Phone Number

Have you retained the services of an attorney? ____NO ____YES

If “YES” please print contact information:

_____

ATTORNEY NAME PHONE NUMBER EMAIL

List all of the medications that you currently are taking, both prescription and non-prescription types. Please provide us with a list if you have one.

Medication: _____ Dosage: _____ How often: _____

Medication: _____ Dosage: _____ How often: _____

Medication: _____ Dosage: _____ How often: _____

Medication: _____ Dosage: _____ How often: _____

Medication: _____ Dosage: _____ How often: _____

Medication: _____ Dosage: _____ How often: _____

Medication: _____ Dosage: _____ How often: _____

Medication: _____ Dosage: _____ How often: _____

Medication: _____ Dosage: _____ How often: _____

PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize Northwest Suburban Pain Center and its physicians, to release and medical records or other information concerning treatment for reimbursement to my insurance companies, employer insurance groups, and other agents or intermediaries, my referring physician, and other physicians participating in the delivery of my pain evaluation, assessment, treatment and care delivery. I understand co-payments, deductibles or amounts not covered by my group health insurance are my responsibility as part of the physician-patient relationship I am establishing with this private physician group.

Patient Signature_____ **Date**_____ / _____ / _____

Parent or Guardian Signature_____ **Date**_____ / _____ / _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**** You May Refuse to Sign this Acknowledgement ****

I have read the Notice of Privacy Practices from the above-named practice. In addition, I want the following information to become a part of my permanent record. I understand that I can make any changes to this document at any time, and unless an individual is listed on this document.
No information will be provided to any individual at any time regarding my care. Regardless of the relationship to me. I also understand that I can request a copy of this document at any time.

I want to authorize leaving messages on my answering machine:

Home: Yes No Cell: Yes No Work: Yes No

The staff of Northwest Suburban Pain Center may leave appointment reminders and messages with the following people who may answer my home/cell/work phone.

Name of Individual	Relationship

I authorize the staff of Northwest Suburban Pain Center to discuss my protected healthcare information with the following people. (PLEASE PRINT)

Name of Individual	Relationship	Phone number

1675 S. Arlington Heights Rd • Arlington Heights, IL 60005 • Phone: 847-255-0900 •Fax: 847-255-4344

PATIENT CONSENT FOR TREATMENT AND RELEASE OF MEDICAL INFORMATION

Patient's Name:

_____

General Consent for Treatment

I consent to and authorize the administration and performance of all tests and treatments by members of the pain management, general medical staff, and personal affiliated with Northwest Suburban Pain Center and Northwest Community Hospital, which in the judgment of my physician(s) and Emergency Dept. or other attending physicians at this institution, may be considered necessary or advisable for the diagnosis and treatment for the condition for which I am presenting myself at this time. I understand that the practice of medicine is not an exact science, and acknowledge that no guarantees have been made to me as a patient.

Disclosure Statement

My care will be managed by my personal pain physician or the physicians who are affiliated with Northwest Suburban Pain Center, who are not employed by the hospital, but who have privileges to care for patients at this institution. My physician may also decide to call in consultants who practice in other specialties who may also be involved in my care. Like my physician, those consultants have privileges to care for patients at the hospital, but are not employed by Northwest Community. To provide specialized services such as emergency medicine, radiology, pathology, and anesthesiology, I understand the hospital has entered into agreements with independent physician groups. The members of these groups are not employees of the hospital, or its day surgery center, but have privileges to practice at these facilities.

Release of Responsibility for Valuables

Patients are requested to make use of the safe at the hospital for any valuables in their possession, or to leave such valuables home when receiving treatment from Northwest Suburban Pain Center. I acknowledge the hospital and the pain center will not be liable for any loss or theft of any personal property of mine, other than that which I deposit in the institutions safe, whether such a loss of theft is occasioned by any patient, visitor, guest, agent, or employee of the institution, the Day Surgery Center, or Northwest Suburban Pain Center.

Release of Medical / Surgical Information

I authorize Northwest Suburban Pain Center to release to my (or the patient's) insurance companies, employer insurance groups, health plans, Medicare/Medicaid program, its insurance carrier intermediaries or agents, any and all medical records or other information concerning my treatment to obtain reimbursement on my (or the patient's) behalf provided by the physicians in this pain group. If appropriate, I authorize the Social Security Administration to release information about my (or the patient's) entitlement to Medicare to Northwest Suburban Pain Center. I also authorize this physicians' group to release and disclose medical records or other information to third parties with which Northwest Suburban Pain Center has contracted for the purposes of reimbursement. I understand I may revoke this consent to release information to third parties at any time, and that the provision of services is not conditioned on my agreement to disclose information to third parties. However, I further acknowledge that if I revoke my consent, and a third-party payer denies payment in whole or part to Northwest Suburban Pain Center, as a result of my refusal to release information, I will be responsible for paying for any and all services rendered by this physicians' group and its employees. This authorization is not intended to allow release of records regarding my treatment for services requiring a restricted release under federal law.

Assignment of Insurance Benefits & Payment Guarantee

I represent at I currently maintain insurance coverage which will reimburse the charges submitted by Northwest Suburban Pain Center and my treating physician for medical or surgical care which is being provide to me. In consideration of those professional physician services, I assign, transfer, and agree to have such physicians reimbursed directly by my insurance company, managed care organization, or health plan through my assignment of such payments to Northwest Suburban Pain Center for all amounts they are entitled to collect from such payers as reimbursement. I assume responsibility and agree to pay all costs, charges, and expenses of every description for services which are given to me by my treating physicians, whether such care is provided inpatient, outpatient, office, or emergency basis. If my medical insurance is not sufficient to satisfy such costs, charges, and expenses in full, I understand that the resulting balance not covered by my assignment of insurance benefits, is my personal responsibility. I agree to pay such established rates for all physician services, procedures, supplies, and medications used for my diagnosis, assessment, treatment, and recovery. If external collection services become necessary to obtain payment from me, I agree to pay all collection agency and attorney fees as well as court costs associated with such collection efforts. I agree that all attorney and collection agency fees that do not exceed one third of the full account balance I owe, are reasonable, and I therefore agree to pay the same.

Acknowledgement

By signing this agreement, I acknowledge that I have read and understand information contained in this consent and release of medical information form, and that I accept its terms. Any parts in this consent form to which I do not agree, have been crossed off and initialed by me. Any exception to this form, have been entered and initialed by me.

Consent for Release and Use of Confidential Information and Receipt of Notice of Privacy Practices Form

I, herby give my consent to the Northwest Suburban Pain Center to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in my patient record. I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice 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 made available upon request beginning on the

revisions effective date. I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

Signed: _____ **Date: _____/ _____/_____**

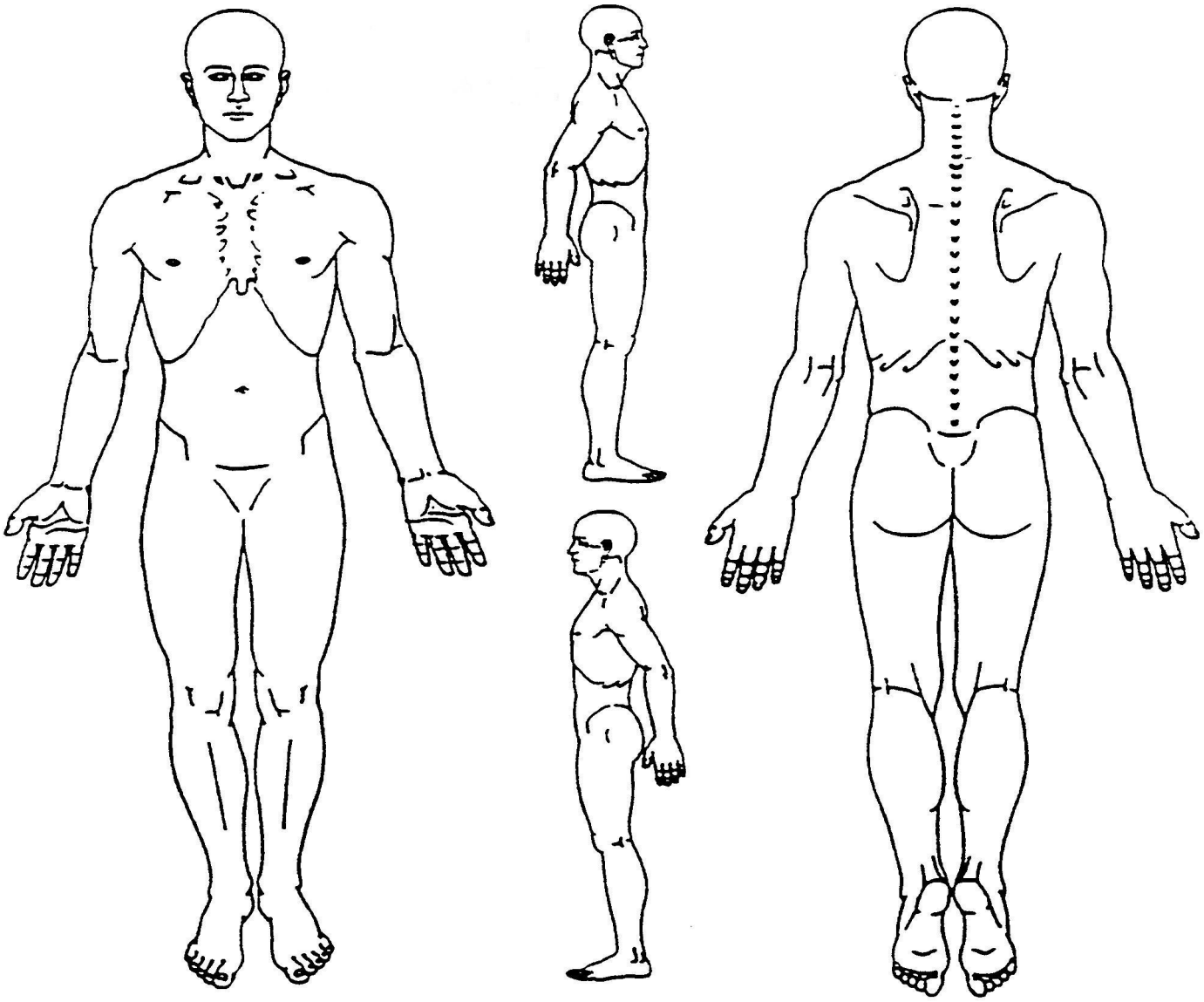
(Name of Patient or Authorized Agent)

If you are not the patient please specify your relationship to the patient:

_____

PAIN DISTRIBUTION DIAGRAM

CIRCLE WHERE YOUR PAIN IS.



PLEASE CIRCLE YOUR LEVEL OF PAIN: (1=MINIMAL OF PAIN; 10=WORSE PAIN)
PAIN CURRENTLY 1 2 3 4 5 6 7 8 9 10
PAIN AT IT'S WORST 1 2 3 4 5 6 7 8 9 10

PAIN TYPICALLY
1 2 3 4 5 6 7 8 9 10

SIGNATURE: _____ DATE: _____/_____/_____

Patient or Guardian Name: _____
RELATIONSHIP TO PATIENT: _____

OFFICE POLICIES AND PROCEDURES AGREEMENT

Welcome!

Thank you for the trust you have placed in our practice. We are committed to providing quality healthcare to you and your family. So that we are sure to meet your expectations consistently, we have prepared a summary of our office policies to answer the most typical questions.

1. Appointments - We will confirm appointments 48 hours prior to the visit. If your scheduled time is not convenient, please notify us at least 48 hours in advance so that we may make this appointment time available to another patient. We make every effort to stay on schedule throughout the day. Unfortunately, because medicine in not an exact science some patients may require more time than others. We will notify you of any extended delays.
2. Proof of Insurance - We will request proof of insurance at each visit. If your insurance has recently changed, please notify us before your next appointment and bring your new insurance card to present at check-in.
3. Co-pays and deductibles - All co-pays and outstanding balances will be collected at check-in; before you are seen.
4. Outstanding Balances - We will notify you on a monthly basis about outstanding balances. At 90 days past due, you must make a "good faith" payment to any outstanding balance. Otherwise, no further appointments will be made. If your balance goes beyond 90 days and remains unpaid. The balance will be referred to an outside collection agency. Any associated collection fees will be added to your balance.
5. Prescriptions - Your provider will write for an appropriate number of refills for chronic medications as allowed by DEA rules. Typically, when these refills expire you are expected to return to the office for a recheck. A new prescription will not be initiated without a face-to-face visit with a provider.
6. Telephone Messages - Every effort will be made to return calls within 24 hours. If there is a medical emergency, please contact 911 or go to the nearest emergency facility. Please refrain from repeat calls regarding the same concerns so we can have focus on all patient messages and return your call ASAP.
7. Insurance - We participate on most of the insurance plans, including Medicare. If you need help finding out if we are in your insurance plan, just ask us. If you are not insured by a plan that we accept we will check your benefits and depending on your deductible we will make every effort to work with you to provide payment option plans. If you have questions about that, please contact your insurance carrier directly.
8. Claim Submissions - As a courtesy, we will submit an insurance claim for the services provided

in our office. If your insurance fails to pay their portion of your charges in a timely manner, we may look to you for payment for those services. Though we may have a contract to participate with your insurance, your individual benefit structure is a contract between you and the carrier.

9. DNR and Power of Attorney- If you the patient have given another individual power of attorney over your medical care; or if you have signed a DO NOT RESUSCITATE order (DNR). Northwest Suburban Pain Center will comply with your decision as long as you provide our office with written proof. Please notify check-in if you do have a DNR or if someone has been given power of attorney. If you do not have a DNR or power of attorney; but do wish for a significant other to be notified regarding your medical care please indicate who that person is on the Notice of Privacy Practices form provided in the new patient packet.

10. Missed Appointments/No shows- We understand that things happen that may interfere with your daily schedule from time to time. A minimum of 24 hours' notice is required for cancelling appointments. Same day cancelations may incur a $30 fee. To ensure that each patient is given enough time for their visit and to provide better quality care, it is important that all scheduled patients arrive on time for their appointment. Appointment cards are provided when scheduling in the office, and 2 reminder calls are made/attempted at 48 hours and 24 hours before your appointment as a *courtesy*.

IF IT IS NECESSARY TO CANCEL YOUR APPOINTMENT, PLEASE CALL OUR OFFICE AS SOON AS POSSIBLE.

If you do not cancel in advance and do not attend the office for your visit. Then the appointment will be considered a "NO SHOW" appointment and a $35 fee will be added to your account; which must be paid by the next visit.

****NO SHOW FEES ARE SOLELY THE RESPONSIBILITY OF THE PATIENT****

11. Dismissal from the Practice- There are several scenarios that may result in dismissal from our practice.

    a. If a balance remains unpaid, even after the collection agency has exhausted their efforts

    b. Verbal abuse of the staff or aggressive behavior will not be tolerated

    c. Repeated missed appointments/no shows

    d. Failure to comply with medical treatment

    e. Falsification of any medical or personal information

Our practice is committed to treating you and your family with care and respect. If you have any questions about these or any other office policies please feel free to contact us during regular office hours.

Sign: _____ **Date:** _____

Northwest Suburban Pain Center

A personal approach to pain management.

1675 S. Arlington Heights Rd. Arlington Heights, IL 60005

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