ADVANCED PHYSICAL MEDICINE

WELCOME

Physical Therapy • Chiropractic • Rehab

ABOUT YOU

Today's Date _____ File # _____

Patient Name _____
(Last) (First) (MI)

What you prefer to be called _____ ○ Male ○ Female

Birth date _____ Age ____ SS# _____

Mailing Address _____

_____

Home Phone _____

Work Phone _____

Mobile Phone _____

Email Address _____

Referred By _____

Employer _____ How Long? _____

Employer Address _____

_____

Occupation _____

Status ○ Minor ○ Single ○ Married ○ Divorced ○ Separated ○ Widowed

Spouse's Name _____

Do you have children? ○ Yes ○ No How Many? _____

INSURANCE INFORMATION

Provider Name _____

Address _____

_____

Phone _____

Insured's SS# _____

Group Number _____

Insured's Name _____

Relation Date of Birth _____

Insured's Employer _____

*Please inform the front desk of a second insurance source

REASON FOR VISIT

Reason for this visit ○ Work ○ Sports ○ Auto ○ Trauma ○ Chronic

What happened _____

_____

Describe the pain and its location _____

_____

When did the condition begin? _____

Is this condition getting worse? ○ Yes ○ No ○ Constant ○ Comes and goes

Condition interferes with ○ Work ○ Sleep ○ Daily Routine

If so, explain _____

Have you had similar conditions in the past? ○ Yes ○ No

If so, explain _____

Have you been treated by a Medical Physician for this condition? ○ Yes ○ No

If so, where _____

Have you ever been treated by a chiropractor before? ○ Yes ○ No

If so, whom _____ Phone _____

CONTINUE ON BACK

HEALTH HISTORY

Are you taking any of the following medications?

○ Nerve pills ○ Pain killers (including aspirin) ○ Muscle relaxers ○ Stimulants
○ Blood thinners ○ Tranquilizers ○ Insulin ○ Other(s) _____

Do you have or ever had any of the following diseases or conditions?

○ Heart Attack/Stroke	○ Heart Surg./Pacemaker	○ Heart Murmur
○ Congenital Heart Disease	○ Mitral Valve Prolapse	○ Artificial Valves
○ Alcohol/Drug Abuse	○ Venereal Disease	○ Hepatitis
○ HIV+/Aids	○ Shingles	○ Cancer
○ Frequent Neck Pain	○ Emphysema/Glaucoma	○ Anemia
○ High/Low Blood Pressure	○ Psychiatric Problems	○ Rheumatic Fever
○ Severe/Frequent Headaches	○ Kidney Problems	○ Ulcers/Colitis
○ Fainting/Seizures/Epilepsy	○ Sinus Problems	○ Asthma
○ Diabetes/Tuberculosis	○ Difficulty Breathing	○ Chemotherapy
○ Lower Back Problems	○ Artificial Bones/Joints	○ Arthritis

List any other serious medical condition(s) you have or ever had

_____

List anything you may be allergic to _____

_____

List previous surgeries/treatments with dates _____

_____

List any past serious accidents with dates _____

_____

Family Health History _____

_____

Do you take supplements or vitamins ○ Yes ○ No Exercise? ○ Yes ○ No

Are you on a special diet? ○ Yes ○ No Since _____

Do you smoke? ○ Yes ○ No How much? _____ How Long? _____

Are you wearing? ○ Heel lifts ○ Sole lifts ○ Inner soles ○ Arch supports

How old is your mattress? _____ Is it comfortable ○ Yes ○ No

For Women: Are you taking Birth Control ○ Yes ○ No

Are you Pregnant? Yes No How long? ____ Nursing ○ Yes ○ No

IN EVENT OF EMERGENCY

Provider Name _____

Relation _____

Home Phone _____

Work Phone _____

Your Medical Doctor _____

Phone _____

ACCOUNT INFORMATION

Person ultimately responsible for account

Name _____

Relation _____

Billing Address _____

_____

SS# _____

Drivers License # _____

Work Phone _____

Payment Method ○ Cash ○ Check ○ Credit

Card # _____ Expiration _____

_____ (Initials) I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting you account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ **Date** _____ ○ Adult Patient ○ Parent or Guardian ○ Spouse

ADVANCED PHYSICAL MEDICINE

PAIN CHART

Physical Therapy • Chiropractic • Rehab

ABOUT YOU

Today's Date _____ File # _____

Patient Name _____
(Last) (First) (MI)

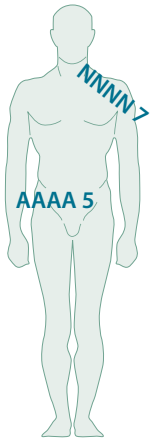
Current weight _____ Height _____

Signature _____

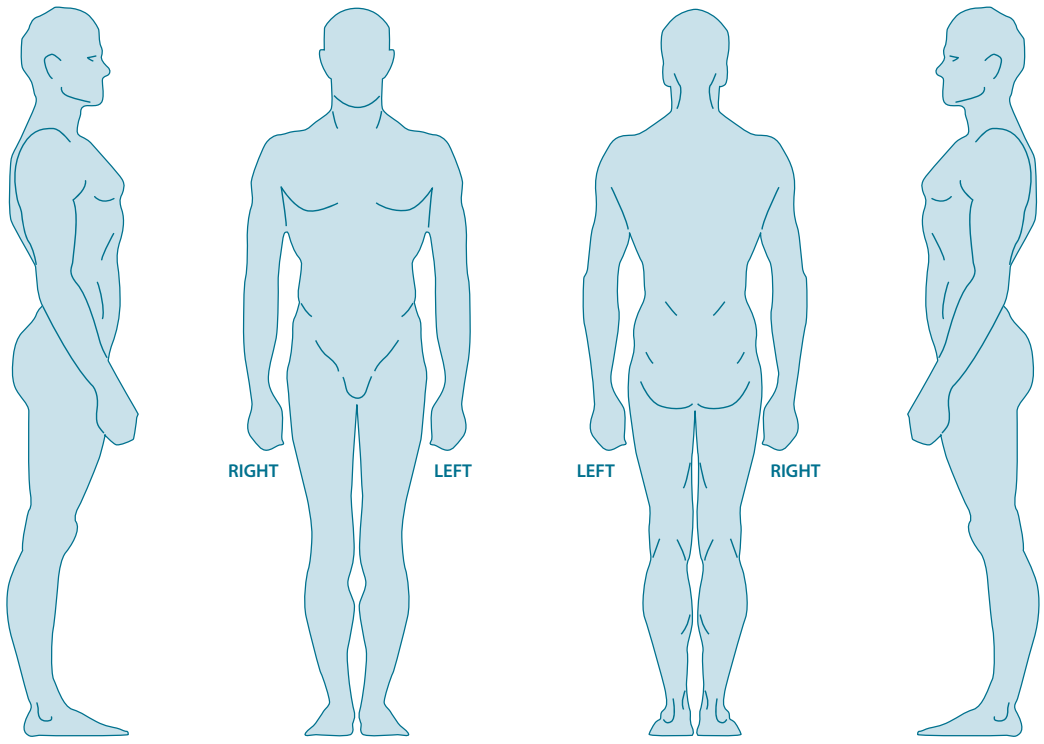
SHOW US WHERE IT HURTS

Please mark area(s) of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

Description Symbol	Numbness NNNN	Pins & Needles PPPP	Burning BBBB	Aching AAAA	Stabbing SSSS



EXAMPLE



Circle any area(s) of pain not represented by a symbol

CONTINUE ON BACK

MEDICAL AUTHORIZATION
(Pursuant to HIPAA & Applicable State Laws)

DESCRIPTION OF THE INFORMATION TO BE USED OF DICLOSED: Any and all documents, information and materials, including, but not limited to: medical. Hospital, clinic, therapeutic, chiropractic or physician's notes, records and charts; any and all medical, hospital, clinic, therapeutic, chiropractic or physician's notes, charts and reports; tests; tests results; operative reports; progress notes; x-rays; radiology reports; enhanced x-ray films (E.M.G.; C.T.; E.E.G.; MRI,; ect.); enhanced x-ray reports; consultant's evaluations, reports or records; admission and discharge summaries; doctor's orders; nurses notes; lab tests; emergency room records and reports; ambulance/ paramedic bills; where applicable, labor and delivery records and reports, pre-natal, fetal monitor strips; anesthesia records, statements for services, and any and all other information or documents, of whatever kind of description, of and pertaining to the said individual's past or present medical condition, care, treatment or rehabilitation, including, but limited to physical and mental condition, examinations made and results thereof, any and all statements of services and charges relating to the above.

IDENTIFICATION OF THE PERSON OR CLASS AUTHORIZED TO MAKE THE USE OR DISCLOSURE OF THE PATIENT HEALTH INFORMATION (PHI):

NAME: _____

ADDRESS: _____

CITY/ STATE/ ZIP _____

DATE OF BIRTH _____ S.S. NUMBER: _____

IDENIFICATION OF THE PERSON OR CLASS TO WHOM THE COVERED ENITITY IS AUTHORIZED TO MAKE USE OF THE DISCLOSURE:

Advanced Physical Medicine Center, S.C.
6931 W. North Ave.
Oak Park, IL. 60302
Phone: (708) 763.0580
Fax: (708).763.9298

A DESCRIPTION OF THE PURPOSE OF THE USE OR DISCLOSURE:

Follow up medical treatment

EXPIRATION DATE OR EVENT: _____, 20_____.

SIGNATURE OF THE INDIVIDUAL, OR THE LEGAL REPRESENATIVE, LEGAL GUARDIAN OR ADMINISTRATOR AUTHORIZED TO ACT FOR THE INDIVIDUAL:

DATE: _____, 20_____. _____

Patient/ Legal Representation/ Legal Guardian/ Authorized Signatory

A PHOTOCOPY OF THIS AUTHORIZATION SHALL HAVE THE SAME FORCE AND EFFECT AS THE ORIGINAL DOCUMENT. THIS AUTHORIZATION DOES NOT AUTHORIZE THE INDIVIDUALS OR ENTITIES TO WHICH IT IS DIRECTED TO TRANSFER OR ASSIGN THIS AUTHORIZATION TO A COMMERICIAL COPYING SERVICE WITHOUT THE EXPRESS WRITTEN CONSENTOR FEE APPROVAL OF THE PATIENT AND ATTORNEY.

THE AUTHOR OR THIS DOCUMENT MAY REVOKE THIS AUTHORIZATION IN WRITING.

THE DOCUMENTS, INFORMATION OR MATERIALS OBTAINED THROUGH THIS AUTHORIZATION MAY BE RE-DISCLOSED BY THE RECIPIENT, AND THUS, MAY NO LONGER BE PROTECTED UNDER THIS PRIVACY RULE.

ADVANCED® PHYSICAL MEDICINE

Physical Therapy • Chiropractic • Rehab

ATTENTION ALL PATIENTS:

DISCLOSURE

IT IS IMPORTANT THAT YOU UNDERSTAND THE NEW HIPAA LAWS REGARDING YOUR PRIVACY HERE AT ADVANCED PHYSICAL MEDICINE CENTER, S.C.

ANY AND ***ALL*** INFORMATION WITH REGARDS TO YOUR ***SOCIAL SECURITY NUMBER*** OR ***ANY INFO*** IN REGARDS TO YOUR ACCOUNT IS STORED IN A LOCKED STORAGE IN OUR OFFICE.

WE DO NOT SHARE OR DISTRIBUTE ANY PERSONAL INFORMATION WITH ANY ENTITY, EXCEPT YOUR INSURANCE CARRIER AND/OR 3RD PARTY INSURANCE.

ALL BILLING IS DONE DIRECTLY FROM OUR OFFICE, ALL INQUIRIES SHOULD BE DIRECTED TO THE OFFICE MANAGER.

ANY FURTHER INQUIRIES IN REGARDS TO THE ABOVE DISCLOSURE SHOULD BE DIRECTED TO EITHER DOCTOR IN THE OFFICE.

I HAVE READ AND UNDERSTAND THE ABOVE POLICY.

_____ _____

PATIENT AND/OR GUARDIANS SIGNATURE DATE

ADVANCED® PHYSICAL MEDICINE

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PATIENT-DOCTOR AGREEMENT

In order for the doctors of Advanced Physical Medicine Center, S.C. to provide their patients with the **BEST** care possible, we have developed this patient-doctor agreement.

Once a treatment plan is set in place, the patient is to follow instructions given by the doctor(s). Any questions or concerns regarding treatment plans address immediately to prevent any confusion.

Missed appointments are the biggest problem we face during our treatment plans. We enforce a **$25.00 fine** to patients who do not call to reschedule or cancel their appointments, without **24 hours** notice. This fine is one to the patient not to any insurance carrier.

The doctors of Advanced Physical Medicine Center S.C., are granted permission by the signature of patient to evaluate and treat any condition the patient presents to our office.
The patient is fully responsible for follow up treatment.

The doctors will not by any means be held liable for any falsifications made on behalf of the patient's health history.

The doctors will not by any means be held liable for any cause(s) of problems due to any related treatment.

The doctors at this clinic are holding a gateway to optimal health, and need your cooperation in order to provide you with a promising future. Let us work together as a team.

Patient signature: _____ Date:_____