Chicago Orthopaedics
& SPORTS MEDICINE, S.C.

PATIENT NAME:_____ TODAY'S DATE_____

Height:_____ Weight_____ Patient's birth date_____

Right handed _____ Left handed _____ Referring Physician_____

CHIEF COMPLAINT & HISTORY OF PRESENT ILLNESS:_____

_____

Is the injury work related? ____Yes ____ No If yes, was injury reported to your employer? ___Yes ___No

Have you been off work? ____Yes ____ No If yes, list date(s):_____

Have you returned to work? ____Yes ____ No If yes, list date:_____

Describe your job: _____

Have you previously had this condition? ___ Yes ___No If yes, when?_____

Have you had previous treatment for this condition? ___ Yes ___No If yes, when?_____

Marital Status: ..... ___ Single ___ Married ___ Divorced ___ Widowed

Use of alcohol:..... ___ Never ___ Rarely ___ Moderate ___ Daily

Use of tobacco:..... ___ Never ___ Previously, but quit ___ Current packs per day

Use of non-prescription drugs: ..... ___ Never Type / Frequency:_____

	YES	NO	PLEASE LIST DETAILS
Do you have any allergies? If yes, to what?. . . .	___	___	_____
Have you ever had a reaction to a drug or medicine? If yes, please list.	___	___	_____

PERSONAL MEDICAL HISTORY

Have YOU been treated or diagnosed ever) For any of the following?

FAMILY HISTORY

FATHER: _____LIVING _____DECEASED

MOTHER: _____LIVING _____DECEASED

	YES	NO	YES Mother/Father	NO
Alcoholism	___	___	_____	_____
Angina	___	___	_____	_____
Asthma	___	___	_____	_____
Bleeding tendency.	___	___	_____	_____
Cancer.	___	___	_____	_____
Cerebrovascular accident (Stroke).	___	___	_____	_____
Coronary artery disease	___	___	_____	_____
Diabetes.	___	___	_____	_____
Epilepsy	___	___	_____	_____
Gastroesophageal reflux disease (GERD)	___	___	_____	_____
Heart attack.	___	___	_____	_____
Hepatitis.	___	___	_____	_____
High cholesterol.	___	___	_____	_____
HIV / AIDS	___	___	_____	_____
Hypertension.	___	___	_____	_____
Pneumonia	___	___	_____	_____
Seizures	___	___	_____	_____
Thrombophlebitis or blood clots.	___	___	_____	_____
Tuberculosis.	___	___	_____	_____
Ulcers.	___	___	_____	_____
Other medical condition(s).	___	___	_____	_____

Have you had previous surgery?.	___	___	_____
If yes, when and what?			_____
Have you been hospitalized for any condition other than surgery? If yes, for what?	___	___	_____

Patient signature_____ ___Check if current list of medications provided

	YES	NO
CONSTITUTIONAL SYSTEMS		
Good general health lately	☐	☐
Recent weight change	☐	☐
Fever	☐	☐
Tired	☐	☐
Headaches	☐	☐
CARDIOVASCULAR		
Heart trouble	☐	☐
Chest pain or angina	☐	☐
Palpitation	☐	☐
Shortness of breath	☐	☐
Swelling of feet, ankles or hands	☐	☐
Muscle discomfort while walking	☐	☐
NEUROLOGICAL		
Light headed or dizzy	☐	☐
Numbness or tingling sensations	☐	☐
Paralysis	☐	☐
Head injury	☐	☐
GASTROINTESTINAL		
Loss of appetite	☐	☐
Nausea or vomiting	☐	☐
Rectal bleeding or blood in stool	☐	☐
Abdominal pain or heartburn	☐	☐

	YES	NO
MUSCULOSKELETAL		
Joint stiffness, swelling or pain	☐	☐
Weakness of muscles or joints	☐	☐
Muscle pain or cramps	☐	☐
Back pain	☐	☐
INTEGUMENTARY (SKIN)		
Rash or itching	☐	☐
Change in skin color	☐	☐
Varicose veins	☐	☐
ENDOCRINE		
Glandular or hormone problem	☐	☐
Thyroid disease	☐	☐
Excessive thirst or urination	☐	☐
Heat or cold intolerance	☐	☐
HEMATOLOGIC/LYMPHATIC		
Slow to heal after cuts	☐	☐
Anemia	☐	☐
RESPIRATORY		
Chronic or frequent coughs	☐	☐
Spitting up blood	☐	☐
Asthma or wheezing	☐	☐

Physician signature_____

Chicago Orthopaedics
& SPORTS MEDICINE, S.C.

PATIENT INFORMATION:

Patient Name:_____
First Middle Last

Address:_____City:_____

State:_____Zip:_____Home Phone:_____Cell Phone:_____

Birthdate:_____ Age: _____ Marital Status: S M W D

Social Security #:_____ Sex: ☐M ☐F Referring Physician: _____

Emergency contact :_____ Phone:_____Relationship to patient_____

Email:_____

RESPONSIBLE PARTY INFO: (guarantor for billing purposes if other than patient)

Name:_____
First Middle Last

Address:_____City:_____

State:_____Zip:_____Phone:_____Relationship to patient:_____

EMPLOYER INFORMATION:

Employer Name:_____Occupation:_____

Address:_____ City:_____

State:_____Zip:_____Work phone:_____

If injury, is it work related? ☐ Yes ☐ No Date of Injury:_____
Is this a personal injury? ☐ Yes ☐ No
Name and phone number of attorney: _____

HEALTH INSURANCE INFO: ***Copy of your insurance cards will be made during the registration process***

Primary Ins. Co. Name:_____

Subscriber name:_____DOB::_____SS#_____

Subscriber employer:_____Subscriber relationship to patient:_____

Secondary Ins. Co. Name:_____

Subscriber name:_____ DOB:_____SS#_____

Subscriber employer:_____Subscriber relationship to patient_____

Signature of patient or parent/legal guardian:

SIGNATURE:_____DATE:_____
Month/ Date/ Year

Chicago Orthopaedics and Sports Medicine
3000 North Halsted, Suite 525
Ellis Nam MD, David Guelich MD, David Hoffman MD,
Charles Mercier MD, William Vitello MD,
CONSENT FOR TREATMENT

I acknowledge and understand that in presenting myself for medical care and treatment at Chicago Orthopaedics and Sports Medicine (COSM) (which includes physical therapy & occupational therapy for the entirety of this agreement), that I authorize and consent to the administration and performance of any tests, examinations, treatments, physical therapy, or occupational therapy, which may be ordered by the physician and/or designated assistant and carried out by COSM &/or PT/OT staff. I understand that this consent will remain in effect until I choose to revoke it in writing.
Minors must be accompanied by a parent or legal guardian in order to obtain medical services.

Patient signature_____***Date***_____

Chicago Orthopaedics and Sports Medicine Financial Policy

ASSIGNMENT OF BENEFITS & AUTHORIZATION TO RELEASE INFORMATION

In consideration of any services rendered to me by Chicago Orthopaedics and Sports Medicine including physical therapy &/or occupational therapy, I hereby authorize and assign any and all reimbursement pertaining to said services to be made on my behalf and paid directly to COSM. If my insurance benefits are provided to me through Medicare, I hereby authorize and assign any and all reimbursement made under my Medicare plan which pertain to any services provided to me by COSM including OT &/or PT to be paid directly to Chicago Orthopaedics and Sports Medicine on my behalf.

I authorize Chicago Orthopaedics and Sports Medicine to release and disclose any medical information about me that pertains to any and all medical care, tests, treatment, or advice that was rendered to me by physicians and/or staff at Chicago Orthopaedics and Sports Medicine &/or physical or occupational therapy to insurance companies, third party payers, authorized agents, claims review organizations, and/or Medicare in order to process a claim and/or payment on my behalf.

PAYMENT AGREEMENT

I understand that providing I present a valid and current insurance card prior to services being rendered, COSM will file a claim to my insurance company but that does not guarantee payment which ultimately I am responsible for. I hereby accept and assume financial responsibility for any covered or non-covered services not paid by my insurance company. I am responsible for providing any referral required by my insurance company prior to services rendered to me and will be responsible for any services that are unpaid as a result of not providing COSM with a valid referral. If there are any questions, problems, or delays regarding my coverage &/or benefits, I understand that it is my responsibility to resolve these issues with my insurance carrier and the COSM billing office.
Deductibles, copayments, and payment for non-covered services will be due at time of service.
Self-pay patients will be expected to pay for their services in full at the time of the visit unless a prior alternate financial arrangement has been made with a COSM authority.

Patient signature_____***Date***_____

*****For patients provided with Durable Medical Equipment a copy of the supplier standards is available on request*****
*****For your information, the health care professionals in this practice are financially integrated. If you are referred to a healthcare professional in this practice for physical or occupational therapy services , please note that you may request & receive a referral for these services outside or independent of this practice.***

Chicago Orthopaedics
& SPORTS MEDICINE, S.C.

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I have received or have been offered a copy of the Notice of Privacy Practices:

☐ Paper

☐ Electronic Mail

_____
Name of Patient

_____
Signature of Individual Acknowledging NPP

Patient Personal Representative (Parent, Guardian, Healthcare Surrogate, Agent)

_____
Employee Witness

_____
Date

This Medical Practice was unable to attain patient acknowledgment of the Notice of Privacy Practices. Please explain below circumstances of the patient's refusal to acknowledge the Notice of Privacy Practices in the section provided below.

☐ Refused to sign

☐ Other:

_____

_____

_____

Employee Signature

_____
Date

Place this form in the medical record

Reference: Notice of Privacy Practices

Effective Date: November 1, 2010

Chicago Orthopaedics & SPORTS MEDICINE, S.C.

Why is COSM asking me questions about my race and ethnicity?

Chicago Orthopaedics and Sports Medicine is participating in a government program focused on improving patient engagement in healthcare and ensuring safe and high quality care. One of the requirements of this program is that we accurately record patients' race, ethnicity and language. In order to comply we are asking that you confirm this information for us.

1. **RACE:**
   - ☐ American Indian or Alaska Native
   - ☐ Asian
   - ☐ Black or African American
   - ☐ Native Hawaiian or Pacific Islander
   - ☐ White
   - ☐ Other
   - ☐ Refuse to Answer

2. **ETHNICITY:**
   - ☐ Hispanic or Latino
   - ☐Non-Hispanic or Latino
   - ☐ Refuse to answer

3. **LANGUAGE:**
   - ☐ English
   - ☐ Spanish
   - ☐ Other _____
   - ☐ Refuse to answer

Orthopaedic Surgery
David R. Guelich, MD
David A. Hoffman, MD
Charles W. Mercier, MD
Ellis K. Nam, MD
William A. Vitello, MD

Practice Manager
Franni Huspen

Podiatry
Douglas Diekevers, DPM

Physician Assistant
Stacy Pinkus, PA-C
Anthony Lizzuzo, PA-C

Practice Location
3000 N Halsted St
Suite 525
Chicago IL, 60657
P 773-433-3130
F 773-433-3127
www.chiorthosports.com

Chicago Orthopaedics & SPORTS MEDICINE, S.C.

Patient Name: _____

Date of Birth: _____ **Date:** _____

Current Pharmacy name, address and phone number:

_____

_____

_____

Current medication list: (Include prescription and non-prescription)

_____

_____

_____

_____

_____

_____

_____

_____

_____

Chicago Orthopaedics
& SPORTS MEDICINE, S.C.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Every visit to a physician or other healthcare provider creates a record that is kept electronically or in paper form, or a combination of both. This record typically includes symptoms, examination notes, diagnoses, test results, and plans of treatment. This Notice of Privacy Practices ("Notice") is applicable to all of the records of your protected health information produced or maintained by this Medical Practice.

We are required by law to maintain the privacy of protected health information, give each patient our Notice, follow the practices listed below and notify you of a breach of unsecured protected health information. Additionally, we are required to revise this Notice of Privacy Practices following the Federal Privacy Standards and provide an internal complaint process for privacy issues.

This Notice relates to Chicago Orthopaedics & Sports Medicine, S.C., including any locations we maintain for providing health care services and products.

Revisions to Notices of Privacy Practices

The language of the Notice applies to all medical records containing your protected health information that we produce or maintain. We reserve the right to change our policies at any time. Changes will apply to medical information about you that we already have as well as any new information after the change takes place. Before we implement significant changes in our policies or privacy practices we will post our new notice. You are entitled to our Notice at any time upon request. You will be asked to acknowledge in writing your receipt of this Notice.

Questions and Complaints

If you have any questions about this Notice, please contact us using the information listed below. If you believe the privacy rights related to your protected health information have been violated you have the right to file a complaint with the individual listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services Office of Civil Rights. Our Privacy Officer will provide you the address upon request.

We support your right to protect the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

HIPAA Privacy Officer
Chicago Orthopaedics and Sports Medicine, S.C.
3000 N. Halsted, Suite 525
Chicago, IL 60657
(773) 433-3130
privacyofficer@chiorthosports.com

Uses and Disclosures of Health Information

We may use and disclose medical information about you for several different purposes. Below find an example of each possible use or disclosure of your protected health information.

Appointment Reminders: We may use or disclose your protected health information to remind you that you have an appointment for healthcare services. Reminders may include written

notifications distributed via the US Postal system, verbal telephone communications and/or messages, or electronic mail or text messages.

Treatment: We may use or disclose your protected health information to treat your medical condition. For example, we may ask you to submit yourself to a laboratory test and we may use the results to obtain a diagnosis. Additionally, we may disclose your medical information to other individuals that may assist in your medical care, such as hospitals, physicians, children, guardians, healthcare surrogates, parents, or a spouse. This practice may also use a sign-in sheet and call patient names in the office waiting room.

Payment: We may use and disclose your protected health information in order to bill and collect payment for the healthcare services provided to you from this office. We may disclose your medical information to another covered entity or health care provider for the payment activities of the entity that receives the information. For example, we may contact your health plan to verify your enrollment and your eligibility for benefits. A disclosure of certain information may also be required for any payments made by credit or debit card or any other electronic means.

Healthcare Operations: We may use and disclose your protected health information in connection to the business of healthcare, including performance improvement, quality of care assessment, risk management and cost management. We may disclose your medical information to another covered entity for health care operations of the entity that receives the information in limited circumstances, if each entity either has or had a relationship to you. We may disclose your information to business associates who assist us in performing our business, such as accountants, lawyers or credentialing organizations.

Further Situations Which Health Information May Be Used and Disclosed

Required by Law. We may use or disclose medical information about you when required by law. This office is required by Federal law to disclose your protected health information to the U.S. Department of Health and Human Service upon request for purpose of determining whether this medical practice is in compliance with the Federal Privacy Standards. We may disclose your health information when authorized by worker's compensation, public health reporting or comparable laws.

We will use or disclose your protected health information in a manner that complies with the following laws:

- Illinois Nursing Home Care Act
- Illinois Mental Health and Development Disabilities Confidentiality Act
- Illinois Medical Practice Act
- Illinois AIDS Confidentiality Act
- Illinois Medical Patient Rights Act
- Illinois Communicable Disease Reporting Act
- Federal Drug Abuse, Prevention, Treatment and Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970

Law Enforcement: We may disclose health information if a request is made by law enforcement officials. For example:

- In connection with criminal conduct at this office
- In an emergency situation, to report a crime, victims of a crime, and the description, location, or identity of the perpetrator
- To identify a suspect, material witness, fugitive or missing person
- Concerning a death believed to be the result of criminal activity; and
- Regarding a crime victim in certain situations

Judicial and Administrative Proceedings: We may disclose health information in the course of any judicial or administrative proceeding in response to a court or tribunal order, qualified protective order or subpoena or other discovery request accompanied by satisfactory assurances you have been notified.

Public Health Activities: This Medical Practice may disclose your health information for public health activities, including:

- To alert a government agency regarding abuse or neglect of an adult patient. However, this office will only disclose this health information if the patient consents or if this office is required or authorized by law to disclose this information.
- For the prevention or control disease, injury or disability
- To report child abuse or neglect;
- To maintain vital records, such as births and deaths
- To report side-effects to drugs or defects with products or devices
- To advise a person regarding possible contact to a communicable disease
- To inform an individual regarding possible risk for spread or contracting a disease or condition
- To alert individuals if a product or device they have has been recalled
- To advise your employer under narrow circumstances associated principally to workplace injury, illness, or medical surveillance.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Abuse, Neglect, and Domestic Violence: We may disclose your protected health information to a government agency if we believe you are a victim of abuse, neglect, or domestic violence. If we make such a disclosure, we will inform you, except if there is a belief that informing you places you at further risk of additional harm.

Serious Threats to Health or Safety: We may use or disclose your protected health information when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of others. Under this situation, we will only disclose health information to an agency or authority able to help prevent the threat.

Specialized Government Functions: We may disclose your protected health information if you are a member of the U.S. or foreign military and if required by the appropriate military command authorities. Furthermore, we may disclose your health information to federal officials for intelligence and national security activities required by law. Additionally, we may disclose your health information to correctional institutions or law enforcement officials if you are an inmate or under the custody of law enforcement officials.

Information About Decedents: We may disclose your health information after your death to coroners, funeral directors or to organizations for organ or tissue donation.

Patient Rights Regarding Health Information

Right to Request Restrictions: You have the right to request a restriction on the use and disclosure of your protected health information for purposes of treatment, payment, and health care operations. We are not required to grant any such request for restriction (unless you plan to pay out-of-pocket for services and do not want the information sent to your insurance company, and tell us in advance) but if the restrictions are granted they will be legally binding, except in certain circumstances. You must fill out a Health Information Restriction Request Form for consideration.

Right to Provide an Authorization for Uses and Disclosures: You have the right to give authorization for uses and disclosures that are not identified by this Notice or are not permitted by applicable law. You must complete the Authorization Form. Any authorization may be revoked at any time in writing. Once an authorization has been revoked, we may not use or disclose your health information for the purposes detailed in the authorization.

Right to Confidential Communications: You have the right to request that we communicate with you by an alternate means or at an alternate location. For example, you may ask this medical practice to contact you by e-mail rather than by phone or traditional mail. We will accommodate reasonable requests.

Right to Access Information: You have the right to see and obtain a copy of your protected health information. We are not required to provide access for all editions and versions of your health information that this office holds, such as psychotherapy notes or records prepared in anticipation of a civil, criminal or administrative hearing. We are required to give you access to health information held in designated record sets for as long as the records are maintained by this office or by our business associates. If such information is maintained in an electronic designated record set, you also have the right to a copy in an electronic format if readily producible in such format. In order to gain access to your health information you must complete the Request to Access Health Information Form. Requests for copies of the designated record set may incur a reasonable fee for the costs of producing the forms. If agreed, we may provide a summary of your health information instead of an exact copy.

Right to a Paper Copy of this Notice: You have the right to a paper copy of this Notice. You may ask us to give you a copy at any time. If you first obtain the Notice electronically, you may still request that we send you a paper copy.

Right to Request Amendments to Health Information: You have the right to request an amendment to your protected health information if you believe it is incorrect or incomplete. A request for an amendment to your health information may be made for as long as the information is kept by us. We may deny your request for an amendment to your health information if we did not create the information or if a determination is made that the disputed health information is accurate and complete. To request an amendment you must complete an Amendment of Health Information Request Form. If we accept the amendment request, you will be informed and you must agree to have the amended health information shared with others. If this medical practice denies the requested amendment, you are allowed to submit a written statement disagreeing with the denial to which we may prepare a rebuttal. All statements will be maintained with your medical record on file.

Right to Receive an Accounting of Disclosures: You have a right to an accounting of disclosures of your protected health information made for purposes other than for treatment, payment and healthcare operations and those disclosures you have authorized. If your health information is disclosed for multiple research purposes we will provide you with a description of the research for which your health information may have been disclosed and the researcher's names and contact information. We may charge you for reasonable retrieval, report preparation and mailing costs incurred in responding to accounting requests in excess of one free accounting every 12 months. You will be advised in advance of the associated fees and given a chance to withdraw or amend a disclosure request. If we maintain your health information in an electronic record, you will receive an accounting of disclosures for all treatment, operations and payment purposes. Accountings of disclosures will cover a maximum period of 6 years.

Other Uses of Medical Information:

Certain uses and disclosures require a patient's authorization. These include most uses and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI. Other uses and disclosures not described in this Notice will be made only with an individual's authorization.