

PATIENT INFORMATION

LAST NAME _____ Sex: Male / Female Marital Status: S / M / W / D

First Name _____ Middle Initial _____ Date of Birth: _____

Home Address _____ Social Security # _____ / _____ / _____

City _____ State _____ Zip _____ Home Phone _____ Cell Phone _____

Employer _____ Work Phone _____

Address _____ City _____ ST _____ Zip _____

Referred by: PLEASE SPECIFY (Attorney / Insurance / Friend / School / Primary Care Physician)

Name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Part(s) of Body injured _____ **Date of Onset** ____ / ____ / ____

Is injury/condition related to: Work / School / Auto accident / Other _____

Do you have an attorney for this injury? YES / NO If yes: Name of attorney _____

Address _____ City _____ ZIP _____ Phone _____

EMERGENCY CONTACT:
NAME/RELATIONSHIP AND PHONE #: _____

MEDICAL INSURANCE INFORMATION

Policy holder's name _____ Policy Holders Date of Birth _____

Policy holder's SSN _____ Policy holder's relation to Patient _____

Employer _____ INSURANCE COMPANY _____

Ins. Co. Address _____ City _____ St _____ ZIP _____ Phone # _____

ID# _____ Group/Policy # _____ Referral required? YES / NO Copay: \$ _____

INSURANCE INFORMATION Please specify: Auto / Workers Comp / Homeowner or Liability

INSURANCE COMPANY _____ CLAIM # _____

Address: _____ City _____ St _____ ZIP _____

Claims Adjustor _____ Phone # _____ ext _____ Fax# _____

I CONSENT TO MEDICAL TREATMENT BY THE CENTER FOR ATHLETIC MEDICINE, LTD AND HEREBY AUTHORIZE THE CENTER FOR ATHLETIC MEDICINE, LTD TO RELEASE INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS. I HEREBY ASSIGN TO THE CENTER FOR ATHLETIC MEDICINE, LTD ALL PAYMEN FOR MEDICAL AND OR SURGICAL SERVICES RENDERED TO ME OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE. I AGREE TO PAY ALL COSTS OF COLLECTION, INCLUDING REASONABLE ATTORNEY'S FEES, SHOULD THIS ACCOUNT BE PLACED WITH FOR COLLECTION.

SIGNATURE _____ DATE _____

Center for Athletic Medicine LTD

Date: ____ / ____ / ____

Patient: _____

Employer: _____

Claim/Group: _____

SS# / ID#: _____

I hereby instruct and direct _____ Insurance Company to pay by check, made out and mailed to:

**Center for Athletic Medicine, LTD
P.O. Box 73569
Chicago, IL 60670**

If my current policy prohibits direct payment to the Center for Athletic Medicine, LTD. I hereby also instruct and direct you to make the check to me and mail it as follows:

**Center for Athletic Medicine, LTD
P.O. Box 73569
Chicago, IL 60670**

For the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. This is a DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above that is mentioned (assignee), and I have agreed to pay, in current manor, any balances of said professional service charges over and above this insurance payment.

A photocopy of this assignment shall be considered effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

I also authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Signature of Policy Holder

Witness

Signature of Claimant/other than policy holder

____ / ____ / ____
Date

HIPAA Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Center for Athletic Medicine, LTD for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of Center for Athletic Medicine, LTD. I understand that diagnosis or treatment of me by Dr. Wolin may be conditioned on my consent as evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Center for Athletic Medicine LTD is not required to agree to the restrictions that I may request. However, if Center for Athletic Medicine LTD agrees to a restriction that I request, the restriction is binding on Center for Athletic Medicine, LTD and Dr. Wolin.

I have the right to revoke this consent, in writing at any time, except to the extent that Dr. Wolin or Center for Athletic Medicine, LTD has taken action in reliance on this consent.

My “protected health information” means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or a healthcare clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand that I have a right to review Center for Athletic Medicine, LTD Notice of Privacy Practices prior to signing this document. The Center for Athletic Medicine, LTD Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations is also provided in the waiting area and on the Center for Athletic Medicine, LTD website at www.athleticmed.com. This Notice of Privacy Practices also describes my rights and the Center for Athletic Medicine, LTD duties with respect to my protected health information.

Center for Athletic Medicine, LTD reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of the privacy practices by accessing the Center for Athletic Medicine, LTD website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Name of patient or Personal Representative

Description of Personal Representative’s Authority

_____/_____/_____
Date

NAME: _____ DATE: _____ / _____ / _____

Date of Birth: _____ / _____ / _____ Height: _____ Weight: _____

CURRENT MEDICATIONS: please list all medications you are currently taking or have taken in the past month.

Name _____ Dosage _____ Frequency _____

Name _____ Dosage _____ Frequency _____

Name _____ Dosage _____ Frequency _____

ALLERGIES	Yes	No	Yes	No	Yes	No		
Any food allergy.....	<input type="checkbox"/>	<input type="checkbox"/>	Inhalation allergy.....	<input type="checkbox"/>	<input type="checkbox"/>	Adhesive tape allergy.....	<input type="checkbox"/>	<input type="checkbox"/>
Any medication allergy.....	<input type="checkbox"/>	<input type="checkbox"/>	Any skin allergy.....	<input type="checkbox"/>	<input type="checkbox"/>	Latex allergy.....	<input type="checkbox"/>	<input type="checkbox"/>

If there are any food or medication allergies please list what they are: _____

PAST SURGERIES/ILLNESSES/ACCIDENTS AND HOSPITALIZATIONS: **NONE** - Or list any hospitalization, accident, serious illness or past surgeries with approximate year at which performed (include minor surgeries such as tonsillectomy, tumors, etc.)

_____ (continue on reverse side)

FAMILY HISTORY: If any of the following have run in your family, please check

FATHER: Allergies Cancer Tuberculosis Diabetes Heart Disease Strokes

MOTHER: Allergies Cancer Tuberculosis Diabetes Heart Disease Strokes

PATIENT HISTORY Yes No Yes No Yes No

HEAD AND NECK

Severe headaches	<input type="checkbox"/>	<input type="checkbox"/>	Double vision	<input type="checkbox"/>	<input type="checkbox"/>	Swelling in neck	<input type="checkbox"/>	<input type="checkbox"/>
Dizzy spells.....	<input type="checkbox"/>	<input type="checkbox"/>	Discharge from ear	<input type="checkbox"/>	<input type="checkbox"/>	Fainting.....	<input type="checkbox"/>	<input type="checkbox"/>
Failing vision	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>

HEART AND LUNGS

Chest pain.....	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack.....	<input type="checkbox"/>	<input type="checkbox"/>	Difficult breathing.....	<input type="checkbox"/>	<input type="checkbox"/>	Spit up blood	<input type="checkbox"/>	<input type="checkbox"/>
Skipping heart beats.....	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Ankles swell	<input type="checkbox"/>	<input type="checkbox"/>
			Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	Any heart defects/murmur	<input type="checkbox"/>	<input type="checkbox"/>

STOMACH AND INTESTINES

Persistent nausea.....	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers.....	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn regularly.....	<input type="checkbox"/>	<input type="checkbox"/>	Skin turn yellow.....	<input type="checkbox"/>	<input type="checkbox"/>	Blood from rectum	<input type="checkbox"/>	<input type="checkbox"/>
Appetite loss.....	<input type="checkbox"/>	<input type="checkbox"/>	Any chronic diarrhea.....	<input type="checkbox"/>	<input type="checkbox"/>	Habitual constipation.....	<input type="checkbox"/>	<input type="checkbox"/>
			Any black stools.....	<input type="checkbox"/>	<input type="checkbox"/>	Have hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>

URINARY TRACT-ETC

						(WOMEN ONLY)		
Any excess urination.....	<input type="checkbox"/>	<input type="checkbox"/>	Any leakage	<input type="checkbox"/>	<input type="checkbox"/>	Painful menstruation	<input type="checkbox"/>	<input type="checkbox"/>
Difficult urination	<input type="checkbox"/>	<input type="checkbox"/>	Passed any stones	<input type="checkbox"/>	<input type="checkbox"/>	Excess menstruation	<input type="checkbox"/>	<input type="checkbox"/>
Any blood in urine.....	<input type="checkbox"/>	<input type="checkbox"/>	Any retention of urine.....	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding between periods	<input type="checkbox"/>	<input type="checkbox"/>
Excess night urination.....	<input type="checkbox"/>	<input type="checkbox"/>				Any missed periods	<input type="checkbox"/>	<input type="checkbox"/>

MUSCLES – JOINTS – NERVES

	Yes	No	Yes	No	Yes	No		
Any tingling sensations	<input type="checkbox"/>	<input type="checkbox"/>	Nervous breakdown.....	<input type="checkbox"/>	<input type="checkbox"/>	Speech disturbances.....	<input type="checkbox"/>	<input type="checkbox"/>
Any Numbness.....	<input type="checkbox"/>	<input type="checkbox"/>	Any memory loss.....	<input type="checkbox"/>	<input type="checkbox"/>	Any seizures	<input type="checkbox"/>	<input type="checkbox"/>
Disturbance in walking	<input type="checkbox"/>	<input type="checkbox"/>	Personality changes	<input type="checkbox"/>	<input type="checkbox"/>	Any emotional problems	<input type="checkbox"/>	<input type="checkbox"/>
Any muscle jerking	<input type="checkbox"/>	<input type="checkbox"/>	Any Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>

Have you or a family member had a history of a blood clot? _____ If "yes", please explain _____

Do you smoke or have you been a smoker? _____ If "yes", describe type, amount and duration of smoking habit _____

Do you drink? _____ If "yes", indicate amount and frequency _____

Has drinking ever been a problem for you? _____

Have you ever been addicted or habituated to drugs? _____ If "yes", please explain _____

Are you on a special diet or do you restrict your diet in any way? _____ If "yes", please explain _____

Other medical problems not listed: _____

Are you currently under the care of another physician for any of the above conditions? Yes No

Patient Signature _____ Date _____ Provider Init _____ Date _____

Center for Athletic Medicine, Ltd.
830 W. Diversey Parkway, Suite 300
Chicago, IL 60614

The Center for Athletic Medicine, Ltd. (CAM) is providing a financial policy to all patients to avoid any misunderstanding or disagreement concerning payment for professional services. Prompt payment allows us to control costs. Outstanding accounts cost both of us time and money; therefore, all patients will be required to establish financial arrangements for payment on their account.

INSURED PATIENTS: our billing staff will submit the claims to your insurance. The patient is responsible for any co-payments, co-insurance, deductible, or non-covered service not payable by your plan. *Please note there are far too many insurance companies to know every patient's benefit plan. To avoid any surprises know your insurance benefits before your first appointment.*

SELF-PAY PATIENTS: will be required to remit full payment to establish an account.

All patient accounts are due and payable within 30 days of services rendered.

Statements will be mailed monthly which is due payable within 30 days. If your payment is not received you will receive one other reminder. If you are unable to pay off your balance please contact your billing representative and a payment plan may be set-up. Any balances after 61 days of notice without a financial arrangement in place will be sent to collection.

Any changes on your account such as address, phone number, insurance, etc., should be brought to our attention as soon as possible to avoid any discrepancies with your account.

OFFICE CHARGES

Office appointments need to be cancelled with-in 24 hours of your scheduled appointment time, or a \$50 failed appointment charge will be assessed to your account.

Scheduled surgeries need to be cancelled with-in 48 business hours of your scheduled surgery time, or a \$1000 charge will be charged on your account.

A \$25 service charge will be charged for any non-sufficient funds check in addition to the amount of the check presented.

Patient/Parent/Guardian Signature

Date