Northwest Orthopaedics & Sports Medicine
Physical Therapy Department
7447 W Talcott Ave. • Suite 501 • Chicago, IL 60631
Phone 773-631-4112 • Fax 773-594-2113

1. Name ____ Date of Birth ___________
2. Occupation ____
   Type of work (i.e. lifting, standing)________________________
3. Past Medical History

Do you have any history of:

- ☐ High Blood Pressure
- ☐ Heart Condition
- ☐ Strokes
- ☐ Diabetes
- ☐ Pacemaker
- ☐ Seizures
- ☐ Cancer
- ☐ Other ________________

4. Have you been admitted to the hospital or undergone any surgical procedure(s) during the last 5 years? ☐ YES ☐ NO
   If yes,
   Year ___________
   What is the condition? ______________________
   What hospital? ____________________
   What was the treatment? ___________________
   Is this condition the reason you were referred to Physical Therapy? ☐ YES ☐ NO
5. Have you received any Physical Therapy treatments during the past 5 years? ☐ YES ☐ NO
   If yes, please specify__________________________________
   What was the treatment? ______________________________
6. Have you had any other previous medical problems or surgeries? ☐ YES ☐ NO
   If yes, please specify__________________________________
7. Have you had any previous orthopaedic problems? ☐ YES ☐ NO
   If yes, name of orthopaedic doctor ______________________
8. Medication
   Type ___________________________
   Reason _________________________
9. Exercise/Activity Level (circle one)
   0-days/week 1-2 days/week 3-5 days/week 6-7 days/week
   Type of activity? ____
10. Primary Care Doctor ____

___________________________________ ________________________

Patient's Signature Date

CONSENT FOR CARE AND TREATMENT

I, undersigned, do hereby agree and give my consent for Northwest Orthopaedics & Sports Medicine Physical Therapy Department to furnish medical care and treatment to ___________________________ considered necessary and proper in treating their physical condition.

Patient/Guardian ______________________________________ Date _________________

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I, hereby assign all medical benefits to include major medical benefits to which I am entitled, Including private insurance and any other health plans to Northwest Orthopedics and Sports Medicine Physical Therapy Department. A photocopy of this assignment is to be considered as valid as the original. I, hereby authorize said assignee to release all information necessary, including medical records to secure payments.

Patient/Guardian ______________________________________ Date _________________

Financial policy statement

It is our policy to bill your insurance carrier as a courtesy to you, although you are responsible for the entire bill when services are rendered. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. If your insurance carrier in excess of the balance of your account subsequently makes any payment, we will promptly refund the credit.

If a payment is made directly to you for services billed by us, you recognize an obligation to promptly remit the same to Northwest Orthopedics and Sports Medicine.

The above does not apply for those patients that are considered workers compensation; however, be advised as a compensation patient that you may be held responsible for your charges in the advance your claim is disputed.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, after such default in upon referral to a collection agency or attorney by Northwest Orthopedics and Sports Medicine, I will be responsible for all costs of collecting money owed, including court costs, collection agency fees, and attorney fees.

ESTIMATED INSURANCE BENEFITS

Estimated patient payment % ___________________________________

Arrangements for payment of patient's share _______________________

Note: Estimated coverage information is provided as a courtesy to our patients, but is not intended to release them from total responsibility for their account balance.

The above information has been read and explained to me. I UNDERSTAND MY RESPONSIBILTY FOR PAYMENT OF MY ACCOUNT.

____________________________________ _________________

Patient /Responsible Party Signature Date

NORTHWEST ORTHOPAEDICS & SPORTS MEDICINE
PHYSICAL THERAPY DEPARTMENT

PATIENT CONSENT FOR TREATMENT AND RELEASE OF PERSONAL INFORMATION

I have been given a copy of the privacy policy and consent to treatment at Northwest Orthopaedic Associates, Ltd. I understand that information about me may be used or disclosed in, the context of normal practice operations, including all treatment, filing of claims, and the receiving of payments for services provided. I understand that information for any other purpose may not be released to anyone without my specific authorization. I may revoke this consent at any time, but it will not have any effect on any actions taken prior to my revoking the consent.

Patient Name ____________________________________ Date ____________________
Please Print

Patient Signature _________________________________

If patient unable to sign:

Patient Representative _______________________________ Date ________________
Please Print

Patient Representative Signature _____________________________

Relation to Patient ____

I have no objection to the physician discussing my medical or surgical care and treatment with the following persons.

Name: ________________________ Relationship: _______________ Phone: _____________
(Please Print)

Name: ________________________ Relationship: _______________ Phone: _____________
(Please Print)

Name: ________________________ Relationship: _______________ Phone: _____________
(Please Print)

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Please fill out the form below, listing all of your current medications, including any vitamins or supplements

Medication	Dosage	Daily Frequency	Mode of Administration (please circle one)
		________________X/DAY OTHER:	ORAL INJECTED INHALED INTRANASAL OTHER:
		________________X/DAY OTHER:	ORAL INJECTED INHALED INTRANASAL OTHER:
		________________X/DAY OTHER:	ORAL INJECTED INHALED INTRANASAL OTHER:
		________________X/DAY OTHER:	ORAL INJECTED INHALED INTRANASAL OTHER:
		________________X/DAY OTHER:	ORAL INJECTED INHALED INTRANASAL OTHER:
		________________X/DAY OTHER:	ORAL INJECTED INHALED INTRANASAL OTHER:
		________________X/DAY OTHER:	ORAL INJECTED INHALED INTRANASAL OTHER:
		________________X/DAY OTHER:	ORAL INJECTED INHALED INTRANASAL OTHER:
		________________X/DAY OTHER:	ORAL INJECTED INHALED INTRANASAL OTHER:

PATIENT DATA SHEET

Last Name	First Name		MI
Address	City	State	Zip Code
Home Phone	Cell Phone		
Work Phone	Email		
Date of Birth	Sex: M F U	Marital Status: S M D W	
Emergency Contact		Phone Number	

RESPONSIBLE PARTY INFORMATION
(IF PATIENT IS A MINOR)

Last Name	First Name		MI
Address	City	State	Zip Code
Home Phone	Cell Phone		
Work Phone	Email		
Social Security #	Date of Birth		Sex: M F U

IS INJURY RELATED TO: (CHECK ONE)

☐ WORK ☐ AUTO ☐ OTHER (EXPLAIN) ____________________

IF CLAIM IS WORK RELATED:

Employer Name		
Employer Address		
City	State	Zip Code
Insurance Carrier	Claim #	
Adjuster	Phone #	Fax#
Billing Address		
City	State	Zip Code

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PATIENT RESPONSIBILITIES

Northwest Orthopedics and Sports Medicine will bill your insurance company. Please have all **current** insurance cards available so that we may copy the front and back of the card for accurate information. It is your responsibility to inform Northwest Orthopaedics and Sports Medicine of **any** insurance changes. If accurate insurance information is not provided for timely submission of a claim, you will be held responsible for the full amount of the charges.

Even within a particular insurance company, there are many policies available. Because of the many differences among insurance plans, we cannot advise you about your particular policy. Resources are available through your insurance company to help you understand your insurance coverage. The services will help you to verify that Northwest Orthopedics and Sports Medicine is a participating provider with your insurance company.

For insurance plans requiring co-pays, these must be paid *prior* to each visit.

I have read the above information. I understand that I am responsible for understanding my insurance coverage. I understand, and agree, that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I except financial responsibility for services not covered by my particular plan.

____
Patients Last, First Name

______________________________ ______________
Patients/ Signature Date

NORTHWEST ORTHOPAEDICS & SPORTS MEDICINE

PHYSICAL THERAPY DEPARTMENT

PRIVACY STATEMENT FOR PATIENTS

Welcome to our practice. In accordance with the Health Insurance Portability and Accountability Act of 1996, our practice is publishing our privacy and security policies for your reference. Your personal information is protected here at Northwest Orthopaedic Associates, Ltd.

Under the law, your protected personal health information may be released to designated health plans or other health care providers without specific authorization in accordance with the law to treat you, obtain payment and conduct normal practice operations. This is called a CONSENT form. We will ask you to sign our consent form for treatment here at Northwest Orthopaedic Associates, Ltd. This consent is valid for all treatment and related operational activity. If you wish to release your protected health information for any other purpose, such as a disability, a life insurance company or a physician not associated with your treatment, you will need to sign a specific authorization.

OUR PRIVACY POLICY

1. Northwest Orthopaedic Associates, Ltd will take all reasonable steps that the minimum necessary amount of information is disclosed to accomplish practice operations, obtain payment for your services and render treatment to you. Such operations include the sending of claims and records to obtain payments, the dictation, typing and filing of medical office notes. Discussion with insurance companies to obtain payment, discussion with collection agencies, i.e., radiologists, laboratory, and other physicians.

2. Your entire medical record will never be released to anyone, unless specifically authorized by you, in writing. You have a right to restrict to whom you allow a portion or all of your record released to. Your records, may, however be released without an authorization in the course of legal investigations by state or federal agencies. Should you need to restrict to whom your records are released, please call or see the Director of Operations.

3. You have a right to inspect your medical records, with reasonable notice to the Director of Operations. You will then be allowed to inspect the records, with the Director present. You have a right to ask that your medical records be amended, however, that is only a request, and the physician is not obligated to comply. You may address a request to the treating physician. Your request will be evaluated and a written response sent to you. The request and reply will be kept in your medical record. If you disagree with the decision of the treating physician, you may request that the President of the Practice evaluate the request. His reply shall be sent to you in writing.

4. If you choose to receive a copy of your medical records, the cost of this will be quoted.

5. We keep a list of all medical record releases here at the practice. You have a right to inspect to whom and when your personal health information is sent to.

6. Our staff and physicians are trained in the policies and procedures concerning the release of protected health information. Each of our staff has signed a Confidentiality Agreement here at Northwest Orthopaedic Associates, Ltd.

7. All complaints regarding the safeguarding of your personal protected health information can be directed to the Director of Operations. You will receive a written reply to any concerns.

8. If there are any changes to this policy statement, it will be posted in our office.

If you need assistance or have questions, please contact our Account Specialists **between 8:30 a.m. and 4:30 p.m., Monday through Friday at 773-631-7898.**