Advanced Physical Medicine of Yorkville

CONFIDENTIAL HEALTH INFORMATION QUESTIONNAIRE

Please fill in ALL portions of this form. If you need assistance, please do not hesitate to ask for help.

Name:____ **Male / Female** **Date:**_________________

Address:_____________________________________ **City:**______________ **State:**____ **Zip Code:**_______

Home Phone:__________________ **Work Phone:**___________________ **Cell Phone:**_________________

Date of Birth:____________ **Age**:_______ **SS#:**______________________**Marital Status:** M S D W

Preferred contact method for appointment confirmation?_______________________________________

E-mail:___________________________________ **Your Occupation:**_______________________________

Employer:_________________________________ **Employer Address:**_______________________________

City:____ **State:**____________ **Zip:**___________

Your Spouse's Name:____

Spouse's Employer:____________________________ **Spouse's Work Phone:**________________________

Emergency Contact Name:_____________________________ **Phone Number:**________________________

Name of nearest relative not living with you:_______________________ **Phone Number:**_____________

Insurance policy holder's name:___________________________________ **Date of Birth:**______________

Insurance policy ID #:__________________________________ **Group #:**____________________________

Is your visit due to a Work or Auto Injury?: Yes No **Date of Injury?:**______________________

How did you hear about our office?:____

SBC Yellow Pages | Home Pages Phone Book | www.AdvancedPhysicalMedicine.net

Flyer In The Mail | Beacon Newspaper | Record Newspapear

Referring Doctor:____

Primary Care Physician:____ **Date of last visit:**__________

If no primary care physician, would you consider our medical doctor as your primary doctor? Yes No

Present Complaints (Circle the appropriate ones):

Headache	Neck Pain	Mid Back Pain	Pins and needles in arm(s):	Right / Left
Low Back Pain	Sinus	Gynecological Issues	Pins and needles in hand(s):	Right / Left
Digestive Complaints	Chest Pain	Shortness of Breath	Pins and needles in leg(s):	Right / Left
Blurred Vision	Cough	Urinary Complaints	Depression	Other:_________________
Knee Pain	Foot Pain	Ankle Pain	Unbalanced	Other:_________________

Difficulty in: Standing Sitting Bending Lifting Twisting Walking

Pain Radiating to the: Right Arm Left Arm Right Leg Left Leg

Cannot Lift: Light Moderate Heavy Repetitive

Other:____

Since the time your complaint began, what have you tried that did NOT work?______________________

Has the problem interrupted your sleep? Yes No

Does anyone in your family have a similar condition?: Yes No **Who?:**________________________

List any doctors or therapists that you have seen for this complaint:

1. ____ Specialty:________________________
2. ____ Specialty:________________________
3. ____ Specialty:________________________

Relevant medical history: (Please circle the conditions you have or had previously)

Arthritis	Epilepsy	Heart Problems	Asthma	Fibromyalgia	Anemia
Stroke	Cancer	High Cholesterol	Hepatitis	Heart Attack	Diabetes
Allergies	GERD	Thyroid Disease	STD	High Blood Pressure	Glaucoma

Other:____

List any operations that you have had and the approximate dates:

1. ____ Date:____________ Doctor:__________________
2. ____ Date:____________ Doctor:__________________
3. ____ Date:____________ Doctor:__________________
4. ____ Date:____________ Doctor:__________________

Are you allergic to any medication?:____

Current Medication List: 1.____________________________ 2.____________________________

3.____________________________ 4.____________________________ 5.____________________________

Do you wear custom fit foot orthotics in your shoes?: Yes No

Are you pregnant?: Yes No **Due date:**___________ **Last Menstrual Period:**___________________

Do you: **Smoke:** Yes No Amount per day:________________

Drink: Yes No Socially Light Medium Heavy

Exercise: Yes No Number of times per week:__________________

I attest that the above information is true and correct to the best of my knowledge.

Patient's Signature:____ **Date:**___________________

Parent or Guardian (Print):____**Date:**___________________

Signature:____ **Date:**___________________

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name: ______________________________ Date: ______________________

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

Headache Neck Low Back

No pain 0 1 2 (3) 4 (5) 6 7 (8) 9 10 **worst possible pain**

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1 - What is your pain RIGHT NOW?

No pain 0 1 2 3 4 5 6 7 8 9 10 **worst possible pain**

2 - What is your TYPICAL or AVERAGE pain?

No pain 0 1 2 3 4 5 6 7 8 9 10 **worst possible pain**

3 - What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain 0 1 2 3 4 5 6 7 8 9 10 **worst possible pain**

4—What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain 0 1 2 3 4 5 6 7 8 9 10 **worst possible pain**

OTHER COMMENTS: ____

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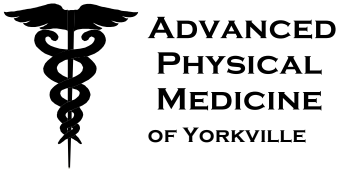


PATIENT CONSENT

CONSENT FOR TREATMENT:

I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

Legal Assignment Of Benefits And Designation Of Authorized Representative:

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage ____, and hereby assign and convey directly to Advanced Physical Medicine of Yorkville, Ltd and all of its employees, as my designated Authorized Representative(s), all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider(s), regardless of such provider's managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize Advanced Physical Medicine of Yorkville, Ltd and all of its employees to release all medical information necessary to process my claims under HIPAA. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from such provider(s) in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to Advanced Physical Medicine of Yorkville, Ltd and all of its employees, to the full extent permissible under the law and under any applicable employee group health plan(s), insurance policies or liability claim, any claim, chose in action, or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s) under any applicable insurance policies, employee benefits plan(s) or public policies with respect to medical expenses incurred as a result of the medical services I received from the Advanced Physical Medicine of Yorkville, Ltd and all of its employees, and to the full extent permissible under the law to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including, but are not limited to, (1) obtaining information about the claim to the same extent as the assignor; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by such provider(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, bring suit by such provider(s) against any such liable party or employee group health plan in my name with derivative standing but at such provider(s) expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

MEDICARE AND MEDICAID CONSENT TO RELEASE INFORMATION:

I certify that the information given by me in applying for payment under Title XVIII and/or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid claim.

x____
Print Patient's Name

x____ x ____________________
Patient's Signature Date

x____ x ____________________
Patient's Guardian, Print Name & Relationship Guardian Signature

 207 Hillcrest Ave. Ste. A Yorkville, IL 60560 630.553.2111

OFFICE FINANCIAL POLICY

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expense and allows you to place your family under care.

1. **If you do not have insurance:** All payments are expected at the time of service or by an authorized payment plan. Your personal balance may not exceed $250 at any time or care may be terminated. Our payment plans make care an affordable part of your family budget.

2. **If you have insurance:** All deductibles and co-payments are expected at the time of service or by an authorized payment plan. Your co-insurance balance may not exceed $250 or care may be terminated. Our payment plans make care an affordable part of your family budget.

You are considered a cash patient until you bring in your completed insurance forms, and we qualify and accept your insurance coverage.

Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.

If your carrier has not paid a claim within (60) days of submission, you agree to take active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment.

If you have a patient balance that is 90 days old or greater, we reserve the right to charge your account 9% interest or up to the maximum allowable by IL law (whichever is greater). You also understand that you will be personally responsible for any fees occurred by Advanced Physical Medicine of Yorkville including collections, court and attorney fees in order to collect a balance due. This fee is in addition to your balance due.

Please note that we reserve the right to charge for phone consultations with the doctors.

*****_**We require a 24 hour notice if you are re-scheduling your appointment. Failure to notify us may result in a minimum $40 charge**_*****

If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

Patient's Printed Name: ____

Guarantor: ______________________________**Signature:** _______________________________ **Date:** ______

Responsible Financial Party (if other than the patient, signature must match name):

Name:________________________________ **Relationship:**_______________________ **Male**____**Female**___

Address:______________________________**City:**____________________**State:**_______ **Zip:**________

Phone:_______________________ **Social Security Number:**__________________ **DOB:**_____________

Signature:______________________________________ **Date**______________

AUTHORIZED REPRESENTATIVE FORM

You may designate another person as your Authorized Representative for purposes of filing an appeal. Except in the case of an urgent care claim, such designations must be made in writing on this form. When you designate a person as your Authorized Representative, it allows that person to deal with the Plan on your behalf but it does not mean that the Plan will send your benefit payments to that person. When you assign benefits (usually on a form that the medical provider supplies), the assignment allows the Plan to pay benefits directly to the medical provider but the medical provider does not become your Authorized Representative because that must be done using this form.

CLAIMANT MUST COMPLETE THE FOLLOWING

The person who has incurred the claim is called the Claimant except that, if the claim is incurred by a dependent child, then the adult who files the claim on behalf of the child is the Claimant. The Participant is the member, employee or retiree whose employment resulted in coverage under this Plan.

Name of Participant	Address, City, State, Zip
Name of Claimant (Patient)	**Address, City, State, Zip (if different)**
Participant's ID Number	**Relationship to Participant**

Personal Representative Appointment

I appoint the individual named below to act on my behalf as my Authorized Personal Representative with my Health Insurance Plan, in connection with:

- ☒ All Appeals (for example: appealing denied claims, etc.)
- ☐ My appeal of denied claim(s) for date(s) of service: [specify dates] ____________________
- ☐ Permission expiration date:___________________. If no date is given, it shall be valid for one year from the date shown below.

Name of Authorized Representative	Address, City, State, Zip
Advanced Physical Medicine of Yorkville, Ltd	***207 Hillcrest Ave. Ste A Yorkville, IL 60560***
Relationship to Claimant	**Telephone Number**
Physician's Office	***630-553-2111***

I understand that:

- The person named above may request and receive any and all information* that would be provided to me, and to act for me in providing any information to the Plan that relates to the appeal for coverage or benefits under the Plan.
- I may revoke this permission at any time by submitting a request in writing to my Health Insurance Plan and/or to Advanced Physical Medicine of Yorkville.
- If this information goes to a health care provider or a health plan covered by federal privacy laws, it is protected by those laws. (Information that goes to other persons or entities may not be protected by federal privacy laws.)
- I have the right to see or copy the health information to be released.
- I do not have to sign this form. If I do not sign this form, the Plan cannot release the information that I have asked to be released (above). The Plan cannot condition treatment, payment, eligibility or enrollment on my signing this form.

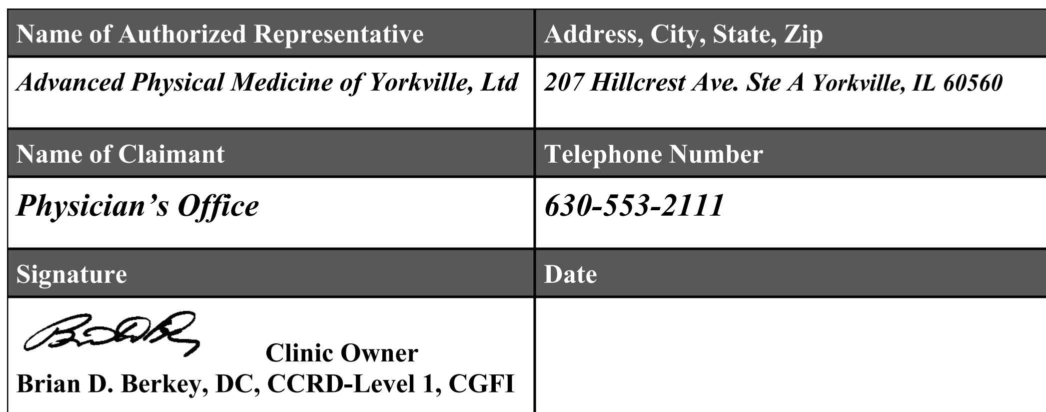
Signature of Claimant

Signature	Date

AUTHORIZED REPRESENTATIVE MUST COMPLETE THE FOLLOWING

Acceptance of Appointment (to be Completed by Authorized Representative)

I accept the appointment as the Authorized Representative as stated above.



Name of Authorized Representative	Address, City, State, Zip
Advanced Physical Medicine of Yorkville, Ltd	***207 Hillcrest Ave. Ste A Yorkville, IL 60560***
Name of Claimant	**Telephone Number**
Physician's Office	***630-553-2111***
Signature	**Date**
Clinic Owner **Brian D. Berkey, DC, CCRD-Level 1, CGFI**	

PARTICIPANT, WHEN THIS FORM HAS BEEN COMPLETED AND SIGNED, SEND TO:
Your insurance company, your local fund, or have your Authorized Representative keep in your records
You may retain a copy of this form for your records upon request

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* Information may include, but is not limited to, information related to the claimant's health care conditions, including psychotherapy notes in summary format.

Notice Of Information Practices

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days with a request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request.

We maintain a history of protected health information disclosures that is accessible to you.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff. We may use your name and/or photograph for correspondence (ie. Monthly newsletter, testimonials, etc.) and in-office news briefs. Should you wish to be excluded from these activities, please submit a request in writing.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

You may file a complaint about privacy violations by contacting our Office Manager.

Name: Pat Jackson Phone: 630-553-2111

The effective date of this Notice of Information Practices is: April 5, 2011

Gregerson Radiology Consults

0S630 Preston Circle, Geneva, IL 60134

Phone 630-845-0862 – Fax 630-578-1018 – Email dgregerson@juno.com

I AGREE TO HAVING MY X-RAYS READ BY A BOARD CERTIFIED RADIOLOGIST

I understand that it is my doctor's policy to have the x-rays taken in his or her office interpreted by a board certified radiologist in order to provide me with the best quality care. I accept that a fee will be charged for the interpretation of my x-rays, independent from any financial agreement made with my referring doctor, and that I am personally responsible for this fee. I understand that, if applicable, my insurance company may be billed directly by **Gregerson Radiology Consults** and that I am personally responsible for any portion of my bill not met by my particular policy, no matter what the reason. I assign and authorize direct payment for any insurance benefits to be paid directly to **Gregerson Radiology Consults** for their professional radiology services. I also authorize release of any medical information concerning my case.

Notice to uninsured and State of Illinois Healthcare (Medicaid) and Medicare patients: there will be a $19 charge per area of body for the reading of the x-rays.

Signed (Insured/Authorized person):_________________________________ **Date:**__________

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I *DON'T* AGREE TO HAVING MY X-RAYS READ BY A BOARD CERTIFIED RADIOLOGIST

If Advanced Physical Medicine of Yorkville, Ltd has taken or will take x-rays, it is strongly recommended that a board certified radiologist review the films. If you choose to not have a licensed radiologist review your films, please sign below:

Due to the following extreme circumstances:____

____,

I am refusing against my doctor's recommendations to have my x-rays read by a board certified radiologist.

Authorized Person Name (Print):______________________________________ **Date:**_________

Signature:____