Illinois Back Institute
Saving People From Surgery!

NEW PATIENT INFORMATION

DATE: ____/____/____

AH__ B__ OP__ WH__ WL__

NAME: _____ _____ _____ DOB: ____/____/____
(First) (MI) (Last)

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____ PHONE: _____

Sex: Male ☐ Female ☐ Marital Status: S ☐ M ☐ D ☐ W ☐ CELL PHONE: _____

PATIENT INFORMATION:

Employer/Occupation:	Social Security:
Work Phone:	E-Mail Address:

How did you find out about us?

☐ TV (Channel ?) _____ ☐ IBI Website ☐ Internet ☐ Facebook ☐ Tribune ☐ OTHER _____

☐ Referral from a physician _____ ☐ Referral from a friend/family _____
(Name) (Name)

☐ Have you had Physical Therapy this year? (Circle one) YES NO If yes, where _____

☐ Have you had Chiropractic services this year? (Circle one) YES NO If yes, where _____

☐ Are you currently enrolled in Home Health Care? (Circle one) YES NO If yes, where _____

☐ Is this related to a Workman's Comp Case? (Circle one) YES NO | Date of Injury? _____
If YES, please provide Billing/Adjustor information to the Front Desk. **Please note:** We do not accept third party liability.

☐ Is this related to Auto Accident Case? (Circle one) YES NO | Date of Accident? _____ State _____
If YES, please provide Billing/Adjustor information to the Front Desk. **Please note:** We do not accept third party liability.

Primary Care Physician: (If other than the referring physician) _____

Address: _____ City: _____ State: _____ Zip Code: _____

Specialty: _____ Phone: _____ Fax: _____

Insurance Information: MUST FILL OUT AND GIVE THE OFFICE A COPY OF YOUR INSURANCE CARD

Primary:	ID	**Insured's Name:**
	Group	**Relationship / DOB**
Secondary:	ID	Insured's Name:
	Group	Relationship / DOB
Tertiary:	ID	Insured's Name:
	Group	Relationship / DOB

Emergency Contact: _____ Phone: _____ Relationship: _____

Individual(s) Illinois Back Institute is authorized to speak to on your behalf:

_____ _____

Assignment of Benefits / Release of Information:

I authorize payment of insurance benefits directly to Illinois Back Institute. I authorize to execute any documents necessary to secure the payment of benefits and obtain any records from any other source necessary for the course of my treatment. I agree to be financially responsible for all charges incurred during treatment by Illinois Back Institute including my insurance deductible, co-payment, and services not covered by my insurance carrier or paid in full through any settlement or court case. Any remaining balances I will pay in full per the policies of Illinois Back Institute.

Patient Signature: _____ **Date**: _____

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New Patient Consultation Form

Name: _____ Age: _____ Date: _____

Please answer the questions below using the check boxes and/or by circling your answers.

1. Are you currently receiving home health care for any service? **Yes** or **No**
2. Where is the Pain?
   ☐ Neck Does the pain radiate? **Yes** or **No** If yes, **right arm – left arm – both arms** ☐ Mid-Back
   ☐ Low Back Does the pain radiate? **Yes** or **No** If yes, **right leg/buttock – left leg/buttock – both legs/buttocks**
3. How long have you had the pain? _____ **weeks / months / years**
4. Is it getting **better** or **worse**? When did it start getting worse? _____
5. On a Scale of 1 – 10, how is the pain on an average day? _____ on a bad day? _____
6. Have you ever seen other doctors for this problem? (check all that apply)
   ☐ Primary ☐ Pain Management ☐ Neurologist ☐ Injections
   ☐ Surgeon ☐ Chiropractor ☐ Physical Therapist ☐ None
7. Have you had any imaging (MRI or CT scan) for this problem within the last year? **Yes** or **No**
   If yes, please bring a copy of the report and disk if available.
8. Have you had any spinal surgeries? **Yes** or **No** If yes, what kind? ☐ Discectomy ☐ Laminectomy ☐ Fusion
   How many total? _____ Date of first surgery _____ Date of most recent surgery _____
9. What kind of pain medications have you tried?
   Narcotic pain medicine (list below) How many pills per day? _____
   _____ _____ _____ _____ _____
   Anti-inflammatory pain medicine NSAIDs (Aleve, naproxen, aspirin, ibuprofen, Advil)
   How many pills per day? _____ Other pain medicine (Tylenol) How many pills per day? _____
10. What is your line of work? _____
11. Have you lost time from work due to the pain? **Yes** or **No** – If yes, approximately how many days? _____
12. Are there things you can't do that you used to do or you would like to do again? _____
    _____
13. What is your goal? _____
    _____

PAD use only:

Pain level today? ____

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Patient Name: _____ Date:_____/_____/_____

Please Circle the correct answer for each question:

1.	Have you ever had blood clots?	Yes	No	
2.	Have you ever had a hernia?	Yes	No	
	a. If yes, How long ago? _____			
3.	Do you have Spondylolisthesis?		Yes	No
4.	Have you ever had a compression fracture?	Yes	No	
5.	Have you ever had a hip, knee or foot implant (artificial)?		Yes	No
6.	Are you pregnant?		Yes	No
7.	Do you have a pacemaker?	Yes	No	
8.	Do you have any metal in your body (Plates or screws)?		Yes	No
9.	Do you have an infection?		Yes	No
10.	Do you have diabetes?		Yes	No
11.	Do you have any stents for your Heart or Arteries?	Yes	No	
12.	Do you have a severe heart problem?	Yes	No	
13.	Do you have epilepsy?		Yes	No
14.	Do you or have you had cancer?		Yes	No
15.	Do you have a history of Osteoporosis?		Yes	No
16.	Do you have a history of Osteopenia?	Yes	No	

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NOTICE OF PRIVACY PRACTICES

Name: _____

In compliance with a newly enacted Federal Law, the **Health Insurance Portability and Accountability Act (HIPAA),** The Illinois Back Institute is informing you of your privacy rights. Please review this notice carefully.

What is HIPAA?
HIPAA is a law passed by Congress in 1996 to improve the efficiency and effectiveness of the healthcare system. It requires health care professionals to adhere to privacy and security standards in order to protect their patient's Personal Health Information (PHI). *PHI is confidential information about a patient, including demographic information.*

What are my rights under HIPAA?
Under HIPAA you have a right to request the following as long as a request is made in writing to the attention of the Privacy Officer and applicable fees are paid. There is a possibility that your request may be denied. If your request is denied we will explain why it was denied in writing.

You have a ***right to inspect and obtain a copy of your PHI.*** We will respond to your request within 30 days. In most cases your request will be honored and a copy of your PHI will be mailed to you.
You have a ***right to request an amendment of PHI.*** If you feel that your PHI is inaccurate or incomplete, you may request an amendment to your PHI. We will respond to your request within 60 days. If we honor your request we will amend your PHI and notify you and applicable parties. We will deny your request if we determine your PHI to be correct or complete, if your request was not created by us, or if PHI is not available for inspection.
You have the ***right to know what disclosure(s) of your PHI have been made***. You have a right to request a listing of who your PHI was sent to, when it was sent, what content of your PHI was sent and for what purpose. We will respond to your request within 60 days. There will be no charge to you for an initial request. Additionally, your request may not include disclosures made for national security reasons, to law enforcement officials/correctional facilities, or disclosures made prior to June 1, 2004 Updated: October 14, 2009.
You have a ***right to request confidential communications of PHI***. We will honor all reasonable requests to keep communications confidential. A reasonable request is one that specifies an alternative address, gives other means of contact and provides detailed information on how payment will be handled.
You have a ***right to request restrictions on the use and disclosure of PHI,*** however we are not required to agree to your request. Your request must state specific restrictions requested and to whom the restrictions would apply.
You have a ***right to receive a hard copy of this notice***. This notice can also be accessed on our website *www.illinoisbackpain.com*.

How will The Illinois Back Institute Use and Disclose PHI under HIPAA?
HIPAA allows us to use and disclose your PHI for the purposes of Treatment, Payment and Healthcare Operations. We will specifically use and disclose your PHI to communicate with your physician and to, upon request, assist your insurance company with the processing of your claims. Additionally, we will use your basic demographic information to notify you of new services or facilities. Your authorization is not required for Use and Disclosure of PHI for the purposes of Treatment, Payment and Healthcare Operations. Listed are other instances in which Use and Disclosure of your PHI is allowed without your authorization.

- ***Disclosure to those Involved in the Individual's Care*** – when necessary, we will make a professional decision to disclose PHI to family members, close friends or other persons involved in and assisting in your care when you approve or when are not able or present to approve.
- ***Uses and Disclosures Required by Law*** – as required by law we are required to use and disclose PHI for the following reasons:
  - Use and Disclose PHI for Public Health Activities – Examples include: communicable diseases, sexually transmitted diseases, lead poisoning, Reyes Syndrome, etc., to public health officials.
  - Disclose PHI about Victims of Abuse, Neglect, or Domestic Violence - Examples include: child abuse and neglect; an abused or neglected nursing home resident; a patient over 60 years old involved in elder abuse.
  - Uses and Disclosure of Health Oversight Activities – we may use and release PHI to be used for audits, investigations, licensure issues, etc.

- Disclosure for Judicial and Administrative Proceedings – we may disclose limited PHI to the appropriate authorities as a result of a court order subpoena, discovery request, etc.
- Disclosure for Law Enforcement Purposes – we may disclose *reasonably necessary* PHI to law enforcement officials to identify or locate a suspect, fugitive, material witness or missing person.
- Uses and Disclosures Related to Decedents – we may use and disclose PHI to a coroner or medical examiner and funeral directors as required by law.
- Uses and Disclosures Related to Cadaveric Organ, Eye or Tissue Donations – we may use and release PHI in order to facilitate organ, eye or tissue donations.
- Uses and Disclosures to Avert a Serious Threat to Health or Safety – we may use and release PHI to public health and other authorities required by law in order to prevent a serious threat to your health or safety.
- Uses and Disclosures for Specialized Government Functions – we may use and release PHI for military/veterans activities and national security/intelligence activities.
- Use and Disclosure of PHI in Emergency Situations - in the event of an eminent threat to the safety of a patient, we may disclose PHI to prevent or lessen the threat.
- ***Uses and Disclosures of PHI for Marketing Purposes*** - The Illinois Back Institute will notify you of new services and facilities unless you specify otherwise. Unless you authorize such a disclosure we will not disclose your PHI for marketing purposes.
- ***Uses and Disclosures of PHI for Research Purposes*** – we do not use or disclose identifiable PHI for research purposes, unless you authorize such use and disclosure.
- ***Uses and Disclosures requiring the Patients Authorization*** - we must obtain your written authorization if we are interested in using and or disclosing your PHI for reasons other than treatment, payment and health care operations. You may revoke your authorization at any time.

What does HIPAA require of The Illinois Back Institute?
The Illinois Back Institute must maintain the privacy of PHI, abide by the terms of this notice and provide patients with a revised notice, if necessary.
Where can I file a privacy complaint?
If you feel your privacy rights have been violated, contact The Illinois Back Institute's Privacy Officer, or contact the regional Department of Health and Human Services at 312-886-2359 or www.hhs.gov.

Receipt of Notice of Privacy Practices Form

Effective June 1, 2004 Updated: October 14, 2009

I, _____, hereby acknowledge receipt of The Illinois Back Institute's Notice of Privacy Practices. The Illinois Back Institute will use or disclose my PHI for the purposes of carrying out treatment, payment and health care operations. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information.

I understand The Illinois Back Institute has reserved a right to change its privacy practices that are described in the Notice. I also understand a copy of any Revised Notice will be provided to me or made available at my next office visit.
I give my consent for The Illinois Back Institute to notify me of new facilities or services. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to The Illinois Back Institute.

Signed: _____ Date: _____

If you are not the patient, please specify your relationship to the patient _____.

Illinois Back Institute
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Oswestry Pain Questionnaire

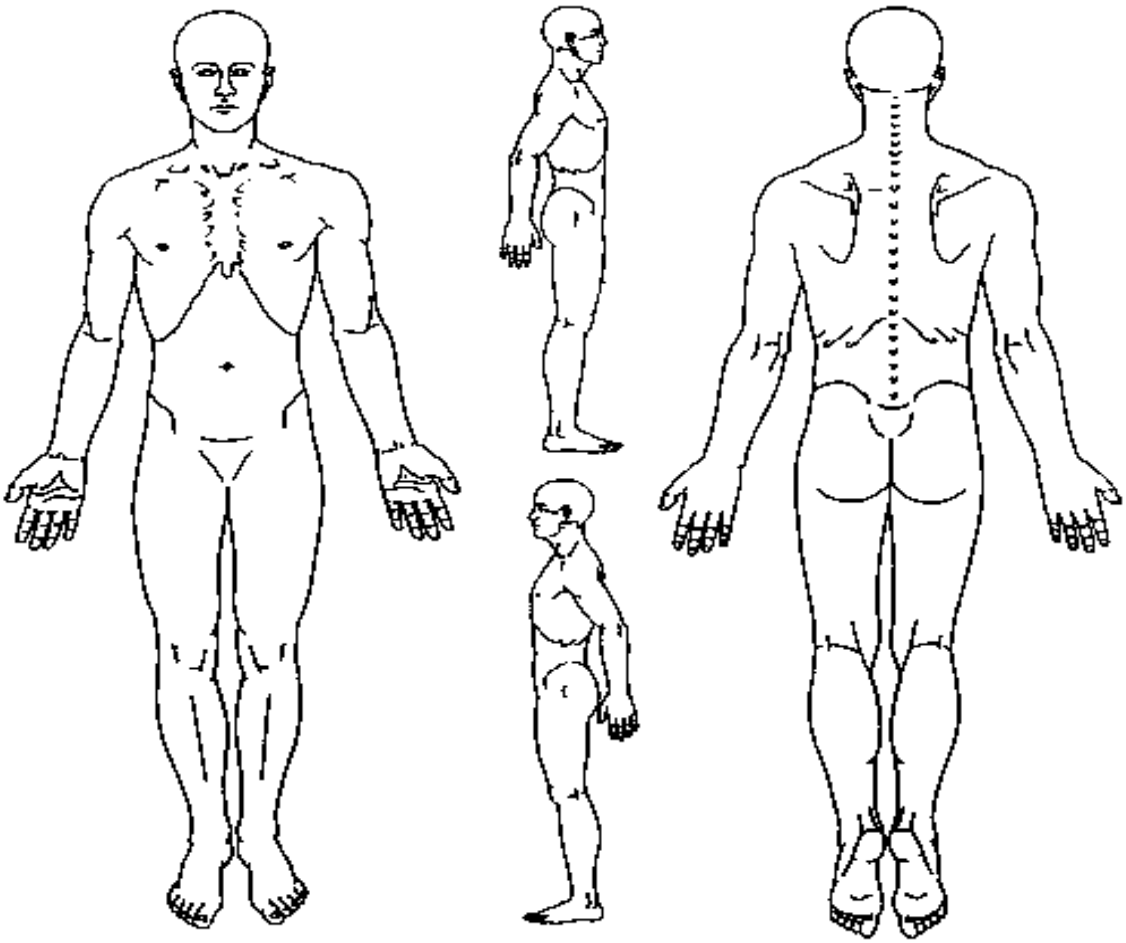
THE NECK DISABILITY INDEX QUESTIONNAIRE

PATIENT NAME: _____ DATE: _____

How long have you had neck pain? _____ years _____ months _____ weeks
On the diagram below, please indicate where you are experiencing pain or other symptoms, right now. Please complete both sides of this form.

A = ACHE B = BURNING N = NUMBNESS

P = PINS & NEEDLES S = STABBING O = OTHER



Illinois Back Institute
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Patient Name: _____ Date: _____

Please Read: This questionnaire is designed to enable us to understand how much your **NECK PAIN** has affected your ability to manage everyday activities. Please answer each Section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but Please **just circle the one choice which closely describes your problem *right now*.**

SECTION 1--Pain Intensity

A. I have no pain at the moment
B. The pain is mild at the moment.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain is severe but comes and goes.
F. The pain is severe and does not vary much.

SECTION 2--Personal Care (Washing, Dressing etc.)

A. I can look after myself without causing extra pain.
B. I can look after myself normally but it causes extra pain.
C. It is painful to look after myself and I am slow and careful.
D. I need some help, but manage most of my personal care.
E. I need help every day in most aspects of self-care.
F. I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3--Lifting

A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example on a table.
D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E. I can lift very light weights.
F. I cannot lift or carry anything at all.

SECTION 4 --Reading

A. I can read as much as I want to with no pain in my neck.
B. I can read as much as I want with slight pain in my neck.
C. I can read as much as I want with moderate pain in my neck.
D. I cannot read as much as I want because of moderate pain in my neck.
E. I cannot read as much as I want because of severe pain in my neck.
F. I cannot read at all.

SECTION 5--Headache

A. I have no headaches at all.
B. I have slight headaches which come infrequently.
C. I have moderate headaches which come in-frequently.
D. I have moderate headaches which come frequently.
E. I have severe headaches which come frequently.
F. I have headaches almost all the time.

SECTION 6 -- Concentration

A. I can concentrate fully when I want to with no difficulty.
B. I can concentrate fully when I want to with slight difficulty.
C. I have a fair degree of difficulty in concentrating when I want to.
D. I have a lot of difficulty in concentrating when I want to.
E. I have a great deal of difficulty in concentrating when I want to.
F. I cannot concentrate at all.

SECTION 7--Work

A. I can do as much work as I want to.
B. I can only do my usual work, but no more.
C. I can do most of my usual work, but no more.
D. I cannot do my usual work.
E. I can hardly do any work at all.
F. I cannot do any work at all.

SECTION 8--Driving

A. I can drive my car without neck pain.
B. I can drive my car as long as I want with slight pain in my neck.
C. I can drive my car as long as I want with moderate pain in my neck.
D. I cannot drive my car as long as I want because of moderate pain in my neck.
E. I can hardly drive my car at all because of severe pain in my neck.
F. I cannot drive my car at all.

SECTION 9--Sleeping

A. I have no trouble sleeping
B. My sleep is slightly disturbed (less than 1 hour sleepless).
C. My sleep is mildly disturbed (1-2 hours sleepless).
D. My sleep is moderately disturbed (2-3 hours sleepless).
E. My sleep is greatly disturbed (3-5 hours sleepless).
F. My sleep is completely disturbed (5-7 hours sleepless).

SECTION 10--Recreation

A. I am able engage in all recreational activities with no pain in my neck at all.
B. I am able engage in all recreational activities with some pain in my neck.
C. I am able engage in most, but not all recreational activities because of pain in my neck.
D. I am able engage in a few of my usual recreational activities because of pain in my neck.
E. I can hardly do any recreational activities because of pain in my neck.
F. I cannot do any recreational activities at all

Patient's Signature: _____ Date: _____
Score _____ % Disability _____

Dr. Signature: _____ Date: _____

Illinois Back Institute
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Oswestry Pain Questionnaire

THE BACK DISABILITY INDEX QUESTIONNAIRE

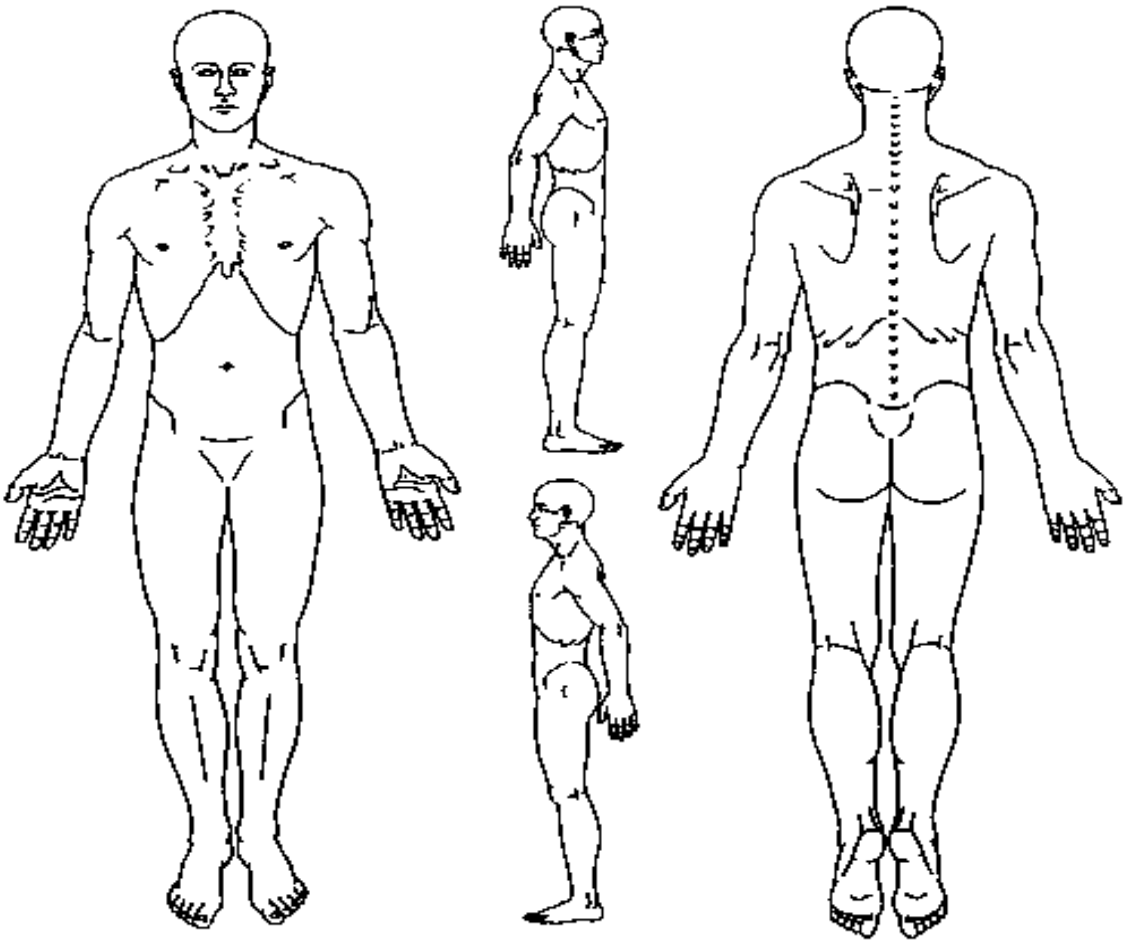
PATIENT NAME: _____ DATE: _____

How long have you had back pain? _____ years _____ months _____ weeks

On the diagram below, please indicate where you are experiencing pain or other symptoms, right now. Please complete both sides of this form.

A = ACHE B = BURNING N = NUMBNESS

P = PINS & NEEDLES S = STABBING O = OTHER



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Patient Name: _____ Date: _____

INSTRUCTIONS: This questionnaire has been designed to enable us to understand how your back pain has affected your ability to manage your everyday activities. Please answer each section by marking the ONE CHOICE that most applies to you. We realize you may feel that more than one statement may relate to you, but PLEASE JUST MARK THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

Pain Intensity	**Personal Care (Washing, Dressing, Etc.)**
❑ The pain comes and goes and is very mild. ❑ The pain is mild and does not vary much. ❑ The pain comes and goes and is moderate. ❑ The pain is moderate and does not vary much. ❑ The pain comes and goes and is severe. ❑ The pain is severe and does not vary much.	❑ I would not have to change my way of washing or dressing in order to avoid pain. ❑ I do not normally change my way of washing or dressing even though it causes some pain. ❑ Washing and dressing increases the pain, but I manage not to change my way of doing it. ❑ Washing and dressing increases the pain and I find it necessary to change my way of doing it. ❑ Because of the pain, I am unable to do some washing and dressing without help. ❑ Because of the pain, I am unable to do any washing or dressing without help.
Lifting	**Walking**
❑ I can lift heavy weights without extra pain. ❑ I can lift heavy weights, but it causes extra pain. ❑ Pain prevents me from lifting heavy weights off the floor. ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table. ❑ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. ❑ I can only lift very light weights at the most.	❑ Pain does not prevent me from walking any distance. ❑ Pain prevents me from walking more than one mile. ❑ Pain prevents me from walking more than ½ mile. ❑ Pain prevents me from walking more than ¼ mile. ❑ I can only walk while using a cane or on crutches. ❑ I am in bed most of the time and have to crawl to the toilet.
Sitting	**Standing**
❑ I can sit in any chair as long as I like without pain. ❑ I can only sit in my favorite chair as long as I like. ❑ Pain prevents me from sitting more than one hour. ❑ Pain prevents me from sitting more than ½ hour. ❑ Pain prevents me from sitting more than ten minutes. ❑ Pain prevents me from sitting at all.	❑ I can stand as long as I want without pain. ❑ I have some pain while standing, but it does not increase with time. ❑ I cannot stand for longer than one hour without increasing pain. ❑ I cannot stand for longer than ½ hour without increasing pain. ❑ I cannot stand for longer than ten minutes without increasing pain. ❑ I avoid standing because it increases the pain straight away.

Illinois Back Institute
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Patient Name: _____ Date: _____

Sleeping	**Social Life**
❑ I get no pain in bed. ❑ I get pain in bed, but it does not prevent me from sleeping well. ❑ Because of pain, my normal night's sleep is reduced by less than one-quarter. ❑ Because of pain, my normal night's sleep is reduced by less than one-half. ❑ Because of pain, my normal night's sleep is reduced by less than three-quarters. ❑ Pain prevents me from sleeping at all.	❑ My social life is normal and gives me no pain. ❑ My social life is normal, but increases the degree of my pain. ❑ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc. ❑ Pain has restricted my social life and I do not go out very often. ❑ Pain has restricted my social life to my home. ❑ I have hardly any social life because of the pain.
Traveling	**Changing Degree of Pain**
❑ I get no pain while traveling. ❑ I get some pain while traveling, but none of my usual forms of travel make it any worse. ❑ I get extra pain while traveling, but it does not compel me to seek alternative forms of travel. ❑ I get extra pain while traveling which compels me to seek alternative forms of travel. ❑ Pain restricts all forms of travel. ❑ Pain prevents all forms of travel except that done lying down.	❑ My pain is rapidly getting better. ❑ My pain fluctuates, but overall is definitely getting better. ❑ My pain seems to be getting better, but improvement is slow at present. ❑ My pain is neither getting better nor worse. ❑ My pain is gradually worsening. ❑ My pain is rapidly worsening.

Patient's Signature: _____ Date:_____

Score _____ % Disability _____

Dr. Signature _____ Date: _____

DIRECTIONS: CIRCLE THE ACTIVITY THAT IS **MORE PAINFUL** OF THE TWO IN EACH PAIR (PLEASE **CHOOSE ONLY ONE** ACTIVITY IN EACH PAIR):

1.	BENDING FORWARD	BENDING BACKWARD
2.	SLEEPING ON BACK WITH KNEES BENT/PILLOW UNDER THE KNEES	SLEEPING ON STOMACH
3.	LYING DOWN IN FETAL POSITION	LYING DOWN ON STOMACH, PROPPED UP ON ELBOWS
4.	SITTING SLOUCHED	SITTING UP TALL
5.	TRANSITIONING FROM STANDING TO SITTING	TRANSITIONING FROM SITTING TO STANDING
6.	SQUATTING/CROUCHING	STANDING
7.	SITTING	WALKING
8.	WALKING UPHILL, ON AN INCLINE	WALKING DOWNHILL, ON A DECLINE
9.	GOING UP STAIRS	GOING DOWN STAIRS
10.	LEANING FORWARD ON GROCERY CART FOR SUPPORT	STANDING STRAIGHT UP TO PUSH GROCERY CART
11.	GOLFING AND/OR PLAYING HOCKEY	RUNNING/SWIMMING
12.	STARTING/INITIAL SWING OF GOLF CLUB	END OF GOLF SWING
13.	WORK REQUIRING CROUCHING (WORKING IN A CRAWLSPACE, ETC)	OVERHEAD WORK (CHANGING A LIGHTBULB, PAINTING, WORKING ON LADDER)

FOR OFFICE USE ONLY:

Total Column 1:_____ *Total Column 2:_____*

Column 1 > Column 2 = Extension bias *Column 2 > Column 1 = Flexion bias*

PATIENT CONSENT AND AGREEMENT TO FOLLOW
ILLINIOS BACK INSTITUTE'S POLICIES AND PROCEDURES

I, understand and hereby acknowledge that by presenting myself for health care services at the Illinois Back Institute ("IBI"), I consent to and authorize my physician(s), physical therapist(s) and other healthcare providers and assistants who may be involved in my care, to provide care and treatment prescribed by and considered necessary or advisable by my physician(s) and/or physical therapist(s). I acknowledge that no guarantees have been made to me about the results of my treatment. I further acknowledge and agree to abide by the following mandatory safety policies and procedures during my care and treatment at IBI:

GENERAL EQUIPMENT/TREATMENT POLICIES ***(please initial each number acknowledging that you have read the item)***

____ 1. IBI clinic is not a "gym" and patients are prohibited from starting, stopping, or adjusting equipment. Adjustments include, but are not limited to, increase/decrease in speed, increase/decrease in incline, increase/decrease in pressure, increase/decrease in traction, and increase/decrease in vibration. **I hereby acknowledge and agree to obtain assistance from Clinic staff for any and all equipment adjustments.**

____ 2. I understand and acknowledge that I am prohibited from running on a clinic treadmill (with or without traction).

____ 3. I understand and acknowledge that I am prohibited from hanging my entire weight on the treadmill traction device. My feet must be on the treadmill at all times during use.

____ 4. When seated in the traction chair, I understand and acknowledge that I may not remove my feet from the foot paddle when the pressure is still on.

____ 5. I understand and acknowledge that Clinic staff must always assist all patients to get onto and off any equipment, including but not limited to traction treadmill, traction chair, vibration table, and vibration devices, or to start/stop any balance, exercise or treatment activity.

____ 6. I understand and acknowledge that I may not attempt to do exercises, including but not limited to in-home exercises, that are outside my prescribed treatment plan and/or otherwise not directed or authorized by Clinic staff and/or my healthcare providers.

____ 7. I understand and acknowledge that I may not get on equipment that was not prescribed for me.

____ 8. I understand and acknowledge that I am not allowed on the Clinic floor when there are no Clinic staff present on the floor to supervise my treatment.

ATTENDANCE AND CANCELLATIONPOLICY (24-Hour Advanced Notice Requirement)

____ 9. I understand and acknowledge the importance of attending therapy consistently and arriving promptly for my appointment. I further acknowledge that my appointment may be rescheduled if I arrive more than 15 minutes late for my scheduled appointment**. I agree to provide at least 24-hour advance notice when I need to cancel or reschedule an appointment and acknowledge that I (not my insurance company) will be charged a $50.00 no-show fee in the event I fail to provide at least 24-hours advanced notice.** In the event of three consecutive no-shows, I acknowledge that my physician will have the discretion to issue a discharge letter disengaging me from IBI and giving me 30 days to enroll with a new physician.

PAYMENT POLICY AND ASSIGNMENT OF BENEFITS

____ 10. I acknowledge that in consideration of the services provided to me by my physician(s), physical therapist(s) and other healthcare providers and assistants, **I am personally financially responsible for payment of my bill**. I hereby assign to and authorize payment directly to IBI of all benefits due me under Medicare, Medicaid, or any insurance policy providing benefits for IBI charges, for services rendered by my physician(s), physical therapist(s) and other healthcare providers and assistants at IBI. I acknowledge that it is my responsibility to provide IBI with current insurance information and to familiarize myself with my insurance plan and its policies. Any questions I have regarding my health insurance coverage

or benefit levels should be directed to my health plan – IBI employees are NOT able to define your insurance coverage. My health insurance plan may provide that a portion of the charges and balance will remain my personal responsibility, such as my deductible, co-payment, co-insurance or charges not covered or denied by my health insurance, Medicare, or other programs for which I am eligible. If you are enrolled in home healthcare and proceed with physical therapy with Illinois Back Institute; you will be 100% financially responsible (if applicable). I certify that I am financially responsible for payment of the services rendered and do hereby unconditionally guarantee the payment of all amounts when and as due, including those not satisfied by the assigned benefits. I agree to pay Illinois Back Institute a $50 NSF fee for any returned checks. The costs of collection include a $75 collection agency fee and/or up to 50% collection cost. **My refusal to sign this form does not change my responsibility for payment in any way.**

ACCESS TO AND RELEASE OF HEALTH INFORMATION POLICY

____ 11. I understand that IBI may document medical and other information related to my care and treatment in electronic and other forms and that such information will be used in the course of my treatment, for payment purposes, and to support those who are caring for me. I hereby irrevocably agree that IBI may disclose, to the extent allowed by law, my medical and financial record to (a) any person or entity which may be liable under contract or by law to IBI or to me, or any person or entity responsible for all or part of IBI's charges, specifically including any insurance company or their agents or employees; (b) any person or entity to whom I have been referred by IBI or by my physician for continued care; (c) any physician treating, consulting or otherwise performing services for me, including his or her employees and agents; and (d) the Centers for Medicare and Medicaid Services, any other governmental or accrediting agency, or their agents or employees. I acknowledge that I have received IBI's Notice of Privacy Practices and that it outlines how my health information will be used and disclosed and how I may gain access to and control my health information.

My signature below constitutes my acknowledgement that: (1) I have read or have had read to me the foregoing IBI policies and procedures, including its General Equipment/Treatment Policies, Attendance and Cancellation Policy, Payment Policy and Assignment of Benefits, and Access to and Release of Health Information Policy, and I understand and agree to them in their entirety; (2) the policies and procedures outlined above have been adequately explained to me by an IBI representative and I have had an opportunity to ask questions; and (3) I authorize and consent to the performance of the procedure(s) and/or treatment(s) deemed advisable by my physician(s) and physical therapist(s) in their professional judgment at IBI.

Patient Signature: _____ Date: _____ Time: _____

Witness Signature: _____ Date: _____ Time: _____

Illinois Back Institute
Saving People From Surgery!

Appointment Text Reminders

The Illinois Back Institute offers the option of receiving text reminders as a convenience to its patients. These text reminders are sent to your cell phone exactly 24 hours before your scheduled appointment time. Please indicate whether or not you would like to receive these text reminders:

☐ I would like to receive text reminders.

My cell phone number is_____.

My cell phone carrier is_____.

☐ I would NOT like to receive text reminders.

Patient Name _____

Patient Signature _____