ISI
ILLINOIS SPINE INSTITUTE

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Spine Surgery

PATIENT INFORMATION	***Date:***		
Patient Name:		Referring Source/Doctor:	Ref. Source/Dr. Ph:
Address:		Primary Doctor(PCP):	Primary Dr. Ph:
City/State/Zip:	Employer/School	Employer/School Address:	
(H) Phone:	Cell Phone:	Work Phone:	Email Address:
Social Security #:	Date of Birth:	Age:	Marital Status:	Sex:
Emergency Contact:	Relationship:	(H) Phone:	Cell Phone:
Pharmacy Name:	Town:	Pharmacy Phone:	Pharmacy Fax:

INSURANCE INFORMATION			
Responsible Party:	Relationship:	DOB:	SSN:
Responsible Party Address:		City/State/Zip:	Phone#:
Primary Insurance:	Employer:	Secondary Insurance:	Employer:
Insurance ID #:	Insurance Group #:	Insurance ID #:	Insurance Group #:
Insured Name:		Insured Name:	
Address:		Address:	
City/State/Zip:		City/State/Zip:	
Insured DOB:	Insured Social Security #:	Insured DOB:	Insured Social Security #:

CONSENT FOR HEALTHCARE AND RELEASE OF MEDICAL INFORMATION:

I consent to evaluation and treatment of the condition for which I, or my dependent, have come to ILLINOIS SPINE INSTITUTE (ISI), and authorize the physicians and other health care providers affiliated with ISI to provide such evaluation and treatment. I understand that the practice of medicine is not an exact science, and acknowledge that no guarantees have been made to me regarding the likelihood of success or outcomes of any examination, treatment, diagnosis, or test performed at or by ISI. I also consent my physician(s) to check my external Rx history. I acknowledge and agree that this consent will be applicable to all visits or episodes of evaluation and treatment at ISI.

I certify that I and/or my dependent(s), have insurance coverage with _____ and assign directly to ILLINOIS SPINE INSTITUTE all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named physician may use my health care information and may disclose such information to the above names insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____ _____

Signature of Patient, Guardian of Personal Representative | Medicare # (if applicable) | Date

_____ _____

Please print name of patient, Guardian or Personal Representative | Relationship to Patient

Illinois Spine Institute, S.C.

Surgical and Non Surgical Spine Care

Payment Policy

PATIENT NAME: _____ DATE OF BIRTH: _____

Thank you for allowing Illinois Spine Institute to be part of your spine care. The following information will help you understand your financial responsibilities.

CONTRACTED PPOs

Co-pays are required whenever seen by a physician and are due at the time of service.

CONTRACTED HMO/EPO/POS

Most of these plans require a referral from your primary care physician and also mandate that you have the referral at the time of the appointment. Without a referral, you will be responsible for all charges at the time of service. If you have your referral with you, your designated co-pay is your responsibility at the time of service.

INDEMNITY INSURANCE/OUT OF NETWORK PLANS

As a courtesy, we will submit claims to your insurance carrier for you, provided that you make available correct Insurance information. We require both the deductible and 20% of the billed charges at the time service is rendered.

WORKERS' COMPENSATION

At the time of your appointment, we require employer's verification that injuries are work related as well as all necessary carrier. Please remember that it is ultimately your financial responsibility for all services if your employer eventually denies your claim.

MEDICARE

Our practice accepts Medicare assignment. Your financial responsibility will include 20% of the Medicare allowable, annual deductible, and non-covered charges. We will submit all portions of your financial responsibility to your secondary insurance carrier, as long as you provide us with appropriate secondary Insurance information.

MOTOR VEHICLE ACCIDENTS (MVA)

For any motor vehicle accidents, automobile insurance must be submitted as primary. Our office submits to your health insurance as a secondary carrier, as long as you provide us with all necessary billing information.

SELF PAY

Payment is due at the time service is rendered. For your convenience, we accept cash, check, money orders and credit cards.

We understand that under unusual circumstances payment in full at the time of service may not be possible. To assist you in payment of the balance, ISI offers the following options:

- Payment plans are available for balance greater than $500. A processing fee of $100 will be assessed and complete payment must made with twelve (12) months. Failure to comply with your payment plan will result in immediate transfer to a collection agency.
- For balance less than $500, ISI will extend credit for 30 days only. Failure to pay within 30 days will result in a processing fee of $100.

It is your responsibility to follow the specific instructions of your particular insurance plan. Furthermore, you are responsible for payment of your account, not your insurance company. In case of divorce, the parent who brings the child in for treatment will be responsible for payment and collecting from all other parties. In the event the account must be referred to collection, I agree to be responsible for the cost of collection, including responsible attorney fees, if any.

A representative from our financial department is always available to assist you.

_____ _____

Signed Patient, or (Parent of Guardian if Minor) Date

PATIENT RECORD OF DISCLOSURES

500 West Golf Road, Suite 101, Schaumburg, IL 60195
360 Station Drive, Suite 200, Crystal Lake, IL 60014
Phone: 847-519-9700 Fax: 847-519-9760

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

ILLINOIS SPINE INSTITUTE HAS MY PERMISSION TO DISCLOSE MY MEDICAL INFORMATION TO THE FOLLOWING PEOPLE:

Patient Name: _____ D.O.B.: _____

Name: _____ Relationship: _____
Name: _____ Relationship: _____

It is the patient's responsibility to notify Illinois Spine Institute, in writing, of any changes to this list of people that are approved for disclosure regarding my medical information.

I WILL BE CONTACTED IN THE FOLLOWING MANNER:

I authorize Illinois Spine Institute to contact me on my cell phone, home phone, or any other telephone number I have provided. Illinois Spine Institute has my permission to leave a message to contact us on any of the phone numbers I have provided.

I authorize Illinois Spine Institute to send any written communication to any address I have provided for you.

It is the patient's responsibility to notify Illinois Spine Institute, in writing, of any change of phone numbers or address change.

ACKNOWLEDGEMENT RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

I acknowledge that Illinois Spine Institute has provided me with a written copy of the Notice of Privacy Practices. I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

I consent to medical treatment and diagnostic procedures by the physicians at Illinois Spine Institute and other affiliates and health care professionals who may be called upon to consult or assist in my care as is necessary in their professional judgment.

Patient Signature: _____ **Date:** _____

Print Name: _____ **Date of Birth:** _____

Signature of Representative/Legal Guardian: _____

Relation to Patient: _____