CHICAGO NEUROSCIENCE INSTITUTE

David H. Durrant, BS, DC, PhD(c), DABCN, FACSP, FIACN

Board Certified Chiropractic Neurologist

Dr. David Durrant is a recognized authority in the fields of neurology and spinecare. Dr. Durrant is a Board Certified Chiropractic Neurologist and currently serves as Director of the Chicago Neuroscience Institute (CNI). He obtained a Bachelor of Science degree in Human Anatomy and Physiology prior to receiving his Doctorate in Chiropractic, Cum Laude, from Logan College of Chiropractic. His post-doctoral training in neurology was completed through Logan College and New York Chiropractic College. Dr. Durrant completed a neurology residency and achieved board certification. He has actively maintained Diplomate Status with the American Board of Chiropractic Neurology, under the auspices of the American Chiropractic Neurology Board. Dr. Durrant has also achieved prestigious Fellow Status with the American College of Spine Physicians and Fellow status with International Academy of Chiropractic Neurology. Dr. Durrant is currently pursuing a Ph.D. in Health Services, with emphasis on the applications of molecular imaging in neurology.

Dr. Durrant has over 25 years of experience in practice which has involved the integration of clinical neurology, neurophysiology, neurogenetics, neuroimaging, and molecular diagnostics. He designed and developed a state-of-the art Human Performance and Gait Lab which is housed at CNI. Dr. Durrant served as an Advisor to the Board of the Marine Military Academy to help implement technologically advanced physical performance measures.

Dr. Durrant is a founding member and officer with the American Academy of Spine Physicians and serves on the Academy Council. He represents the United States on the Board of the International Spine Association (ISA). Dr. Durrant is an accomplished neuroscience author and editor having authored numerous articles and textbook chapters in the field of neurology. He is the principal author and co-editor of the textbook titled, MYELOPATHY, RADICULOPATHY AND ENTRAPMENT AND SYNDROMES, a benchmark publication in neurology. Dr. Durrant has lectured for many academic venues throughout the country. He is often asked to speak on topics related to emerging trends in neurology and spinecare.

CHICAGO NEUROSCIENCE INSTITUTE

Registration

Date: _____

Patient Information

Patient Name: _____
First Name Last Name Initial

Legal Guardian: _____
(If a minor under the age of 18)

Your Street Address: _____ Email: _____

City: _____ State: _____ Zip: _____

Work Phone: _____ Home Phone: _____ Mobile Phone: _____

Social Security #: _____ Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Age: _____ Birthdate: _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed

Student Status: ☐ Full Time ☐ Part Time ☐ Not currently a student

Employment Information

Patient employed by: _____

Business Address: _____

City: _____ State: _____ Zip: _____

Your Occupation: _____

Spouse Information

Spouse Name: _____ Birthdate: _____

Spouse's Employer and Business Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____ Business Phone: _____

Spouse's Social Security #: _____

Are you covered under any of the following programs? ☐ Medicare ☐ Medicaid ☐ CHAMPUS ☐ CHAMPVA

Is your condition related to your employment? (current or previous) ☐ No ☐ Yes ☐ Don't know If yes, date of accident: _____

Is your condition related to an automobile accident? ☐ No ☐ Yes If yes, in which state? _____ Date of accident: _____

Have you been involved in an automobile accident in the past three years? ☐ No ☐ Yes Date of accident: _____

Other type of accident? ☐ No ☐ Yes Please describe: _____ Date of accident: _____

In case of emergency, who should we notify? _____

Phone Number: _____ Relationship to patient: _____

Please list other doctors you have seen in the past 5 years

1. _____ City/State: _____

Reason for seeing: _____

2. _____ City/State: _____

Reason for seeing: _____

Whom may we thank for referring you: _____

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Health Questionnaire

Date: _____ Patient Name: _____ Birthdate: _____ SS#:_____

Primary reason for visit:_____

Have you been treated for this problem before: ☐ No ☐ Yes If yes, by ☐ Medical physician ☐ Chiropractic physician

When did your symptoms first appear? _____ Is this condition getting worse? ☐ No ☐ Yes ☐ Unknown

Is it ☐ constant or ☐ does it come and go? Does it interfere with your ☐ Work ☐ Sleep ☐ Activities of daily living ☐ Recreation

Movements which are painful to perform: ☐ Sitting ☐ Walking ☐ Bending ☐ Lying down ☐ Driving a car

Your occupation:_____
(Describe your work activities - sitting, lifting, driving, desk work, etc.)

Are you currently working ☐ Yes ☐ No. If no please indicate your first day of disability _____

Do you take ☐ Muscle relaxers ☐ Pain killers ☐ Insulin ☐ Birth control pills ☐ Over the counter meds.

Does coughing, straining, or sneezing bother you ☐ Yes ☐ No

Please describe your	Sitting Tolerance	Standing Tolerance	Walking Tolerance
	☐ None	☐ None	☐ None
	☐ Less than 1 hour	☐ Less than 1 hour	☐ Less than 2 blocks
	☐ Less than 3 hours	☐ Less than 3 hours	☐ More than 2 blocks
	☐ More than 3 hours	☐ More than 3 hours	

List any surgeries you have had in the pas (Include Surgical Date)t:

Do you smoke? ☐ Yes ☐ No ___ # Pks./day ☐ <10yrs or ☐ > 10 yrs

Social drinking? ☐ None ☐ < 5 ☐ >10 PER / ☐ Day ☐ Week ☐ Month

Marital status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Family history	Age	Alive	Deceased	High blood pressure	Heart disease	Diabetes	Stroke	Neurologic Disease	Cancer	Overweight
Father	_____	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mother	_____	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sibling	_____	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sibling	_____	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sibling	_____	☐	☐	☐	☐	☐	☐	☐	☐	☐

List any prescription medications or vitamins you are currently taking with dosage:

Medications:	Vitamins:

Any known allergies?

Date of last: Physical Exam: _____ Spinal X-rays: _____ Blood/Urine tests: _____

Neurologic Exam: _____ Nerve Studies/EMG: _____ MRI, CT-scan, Bone scans: _____

ECG/EKG: _____ Angiogram: _____ Peripheral Vascular (Doppler) _____

Where were studies performed: _____

Conditions: Check conditions you have or have had in the past.

☐ Autoimmune Disorder	☐ Diarrhea	☐ Hepatitis	☐ Constipation
☐ Alcoholism	☐ Diabetes	☐ Herniated disc	☐ Kidney disease
☐ Anemia	☐ Digestive Disorders (IBS, Crohn's UC)	☐ High cholesterol	☐ Prostate problem
☐ Appendicitis	☐ Emphysema	☐ HIV positive	☐ Psychiatric care
☐ Arthritis	☐ Epilepsy	☐ High Blood Pressure	☐ Rheumatoid arthritis
☐ Alcoholism	☐ Emphysema	☐ High Cholesterol Triglycerides	☐ Rheumatic fever
☐ Asthma	☐ Food Allergies	☐ Light Headedness/Dizziness	☐ Scarlet fever
☐ Bells palsy	☐ Foot pronation	☐ Liver disease	☐ Spinal Stenosis
☐ Bleeding/clotting disorders	☐ Facial weakness	☐ Leg Edema/swelling	☐ Stroke
☐ Breast lump	☐ Fractures	☐ Migraine headaches	☐ Suicide attempt
☐ Bronchitis	☐ Gall Bladder Disease	☐ Miscarriage	☐ Stress or irritability
☐ Cancer	☐ Glaucoma	☐ Mononucleosis	☐ Sensitivity to sun and light
☐ Carpal tunnel syndrome	☐ Gout	☐ Multiple sclerosis	☐ Thyroid disease/problems
☐ Cataracts	☐ Heart disease	☐ Measles	☐ Tonsillitis
☐ Chemical dependency	☐ Heart murmur	☐ Osteoporosis	☐ Tuberculosis
☐ Chicken pox	☐ Heart arrhythmia	☐ Pacemaker	☐ Ulcers
☐ Depression	☐ Head injury/concussion	☐ Polyneuropathy	☐ Venereal disease

General Symptoms: Check symptoms you have or have had in the past year.

GENERAL NEUROLOGIC

- ☐ Depression
- ☐ Difficulty sleeping
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Difficulty w/short term memory
- ☐ Difficulty w/long term memory
- ☐ Headaches
- ☐ Loss of sleep
- ☐ Fragmented sleep
- ☐ Cognitive Impairment
- ☐ Nervousness
- ☐ Numbness or tingling
- ☐ Sweats
- ☐ Tiredness
- ☐ Weight gain
- ☐ Hallucinations
- ☐ Difficulty w/word retrieval
- ☐ Muscle twitching
- ☐ Gait abnormalities

GENITO-URINARY

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination
- ☐ Difficulty voiding

CARDIOVASCULAR

- ☐ Calf cramping
- ☐ Chest discomfort/pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Exertional leg pain
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins
- ☐ Shortness of breath

EYE, EAR, NOSE, THROAT

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Vision - flashes
- ☐ Vision - halos
- ☐ Intermittent loss of vision
- ☐ Hallucinations

MEN Only

- ☐ Breast lump
- ☐ Impotence
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis

WOMEN Only

- ☐ Abnormal pap smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge

Date of last menstrual period: _____

Date of last pap smear: _____

Have you had a mammogram? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

Number of children: _____

SPINE, FACE, AND EXTREMITY PRESENTATIONS: Check symptoms you have or have had in the past year.

NECK (Cervical Spine)

- ☐ Neck stiffness
- ☐ Neck weakness
- ☐ Pinched nerve in neck
- ☐ Neck feels out of place
- ☐ Muscle spasms in neck
- ☐ Grinding/popping sounds in neck

SHOULDERS

	Right	Left
☐ Pain in shoulder joint	☐	☐
☐ Pain across the shoulders	☐	☐
☐ Can't raise arm	☐	☐
☐ Above shoulder level	☐	☐
☐ Overhead	☐	☐
☐ Tension in shoulders	☐	☐
☐ Pinched nerve in shoulder	☐	☐

MID-BACK (Thoracic Spine)

- ☐ Mid-back pain
- ☐ Mid-back stiffness
- ☐ Pain between shoulder blades
- ☐ Muscle spasms in mid-back

ARMS & HANDS

	Right	Left
☐ Pain in upper arm	☐	☐
☐ Pain in elbow	☐	☐
☐ Pain in forearm	☐	☐
☐ Pain in hand	☐	☐
☐ Pain in fingers	☐	☐
☐ Pins & needles in arm	☐	☐
☐ Pins & needles in fingers	☐	☐
☐ Numbness in arm	☐	☐
☐ Numbness in fingers	☐	☐
☐ Weakness of arm	☐	☐
☐ Weakness of hand	☐	☐
☐ Hands cold	☐	☐
☐ Muscle twitching		

LOW BACK (Lumbar Spine)

- ☐ Low back pain
- ☐ Low back stiffness
- ☐ Low back feels out of place
- ☐ Muscle spasms in low back
- ☐ Muscle spasms in low back

HIPS, LEGS, & FEET

	Right	Left
☐ Numbness/Tingling	☐	☐
☐ Pain in buttocks	☐	☐
☐ Pain in hip joint	☐	☐
☐ Pain down leg	☐	☐
☐ Pain in knee	☐	☐
☐ Pain in ankle	☐	☐
☐ Pain in foot	☐	☐
☐ Weakness of lower leg	☐	☐
☐ Weakness of upper leg	☐	☐
☐ Weakness of knee	☐	☐
☐ Leg cramps	☐	☐
☐ Muscle twitching		

FACE

	Right	Left
☐ Numbness	☐	☐
☐ Weakness	☐	☐
☐ Pain	☐	☐
☐ Pins and needles	☐	☐

Please list other doctors you have seen in the past 5 years

1. _____ City/State: _____ Reason For Seeing: _____
2. _____ City/State: _____ Reason For Seeing: _____
3. _____ City/State: _____ Reason For Seeing: _____
4. _____ City/State: _____ Reason For Seeing: _____

Whom may we thank for referring you: _____

I certify that the above information is correct to the best of my knowledge. This health history is accurate and thorough in order aid the physician to recommend the proper care that I might require. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature: _____ Date: _____

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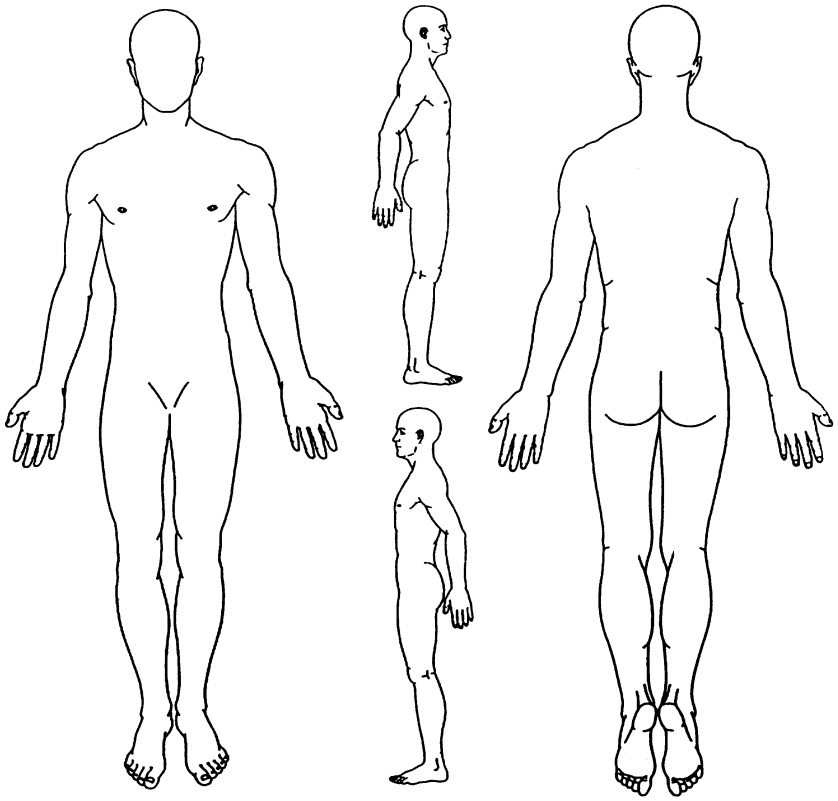
Pain Diagram

Name : _____ **Date:** _____

Draw the location of your pain on the figures below using the following symbols:

Ache	Burning	Numbness	Pins and Needles	Stabbing	Other
ΛΛΛΛ	= = = =	ooooo	• • • • • • • •	//////////	XXXXX
ΛΛΛΛ	= = = =	oooo	• • • •	//////	XXX



A.

Pain Intensity Line

B.

Pain Intensity Line

C.

Pain Intensity Line

D.

Pain Intensity Line

No Pain
0

Worst Possible
10

Mark the level of pain you feel on a daily basis

IF THERE IS PAIN AT MORE THAN ONE AREA, PLEASE COMPLETE A PAIN INTENSITY LINE FORE EACH AREA.

Patient Signature: _____ Date: _____

CHICAGO NEUROSCIENCE INSTITUTE

Consent for Care/Treatment

1. I hereby authorize and voluntarily consent to care/treatment for my condition(s) at the Chicago Neuroscience Institute, Ltd. (hereinafter referred to as CNI), which may include the performance of diagnostic procedures, interpretation of diagnostic studies including imaging, the administration of medication, nutritional supplementation, chiropractic care, joint and soft tissue manipulation, physical therapy and procedures requiring the use of needles as deemed necessary by my physician(s), his or her assistants, consultants, or designees for the diagnosis or treatment of my disorder(s)/illness(es).

2. I understand and am informed that in the practice of medicine and chiropractic, as in other forms of health care delivery, there are some risks associated with some diagnostic tests and therapeutic procedures, including but not limited to bruises, pain, fractures, allergic reactions, disc injury, stroke, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts as then known, is in my best interest.

3. Realizing that outpatient care/treatment requires the cooperation of physicians and support healthcare personal to include nurses, therapists and technicians, I hereby give consent for their communication and all procedures provided to me by qualified physicians and other personnel working under the supervision and direction of my attending physician at CNI.

4. I am aware that the practice of medicine and chiropractic is not an exact science and I hereby acknowledge that no guarantees have been made to me as to the result of examinations, treatments or recommendations.

5. I hereby authorize CNI to retain, preserve and use for scientific or teaching purposes, or dispose of at their convenience, any specimens or tissue taken from my body during my care at CNI.

6. I hereby understand that the responsible third party or I may be billed for the completion of submitted paperwork and for review of any outside medical records or imaging studies. This includes record reviews for the purpose of a second opinion and clinical correlation.

7. I understand that a specialized diagnostic or focused therapeutic approach to neurological or related orthopedic conditions at CNI is not to take the place of my general healthcare. I understand that I should consult with my personal/family medical physician/medical internist for general care and for the coordination of my healthcare with other specialists. It is the policy of CNI to recommend that each patient receive at a minimum semi-annual comprehensive examinations from their attending medical internist/medical family physician unless deemed otherwise. This approach helps facilitate timely diagnosis and intervention.

8. I understand that if I am seeking a diagnostic opinion at CNI I am responsible to follow up with the recommended physician(s) for review of therapeutic options and/or intervention. If I do not follow through with the recommended course of care including diagnostic follow-up, I understand that it could lead to an unwanted outcome including but not limited to chronic pain, physical disability, loss of limb, cognitive impairment or death.

9. I understand that CNI provides facilities, equipment and clerical support services for of physicians so they may render diagnostic and therapeutic services to their patients. I recognize with the exception of designated "staff CNI physicians", the physicians rendering services to me, including but not limited to, attending physicians, consultants, pathologists, radiologists and neurosurgeons are independent practitioners and are not employees or agents of CNI and may not be covered by CNI managed care plans. In some cases I can expect to receive a separate bill from the independent physicians providing services at CNI.

10. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about the content, and by signing below I certify that I understand its contents. I intend this consent form to cover the entire course of evaluation and care for my present condition, complications related to my condition and for any future condition(s) for which I seek treatment.

Signature of Patient/Legal Guardian:_____ Date:_____

Printed Name:_____ Date:_____

Witness:_____ Date:_____

CHICAGO NEUROSCIENCE INSTITUTE

NOTICE OF PRIVACY PRACTICES

In compliance with a newly enacted Federal Law, The Health Insurance Portability and Accountability Act (HIPAA), CHICAGO NEUROSCIENCE INSTITUTE, LTD. is informing you of your privacy rights. Please review the information below.

What is HIPAA? HIPAA is a law that was 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 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 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 April 14, 2003.
- 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.CNIHealth.com.

How will Chicago Neuroscience Institute, Ltd. use and disclose PHI under HIPAA? HIPAA allows us to use and disclose your PHI for the purposes of providing **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, or other third party payoff 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 purpose of **Treatment, Payment and Healthcare Operations**. Listed are other instance 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, Nelglect, or Domestic Violence-Examples include: child abuse and Negkect; or Domestic Violence- Examples include; child abuse and neglect; an abuse 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, and 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 Purpose-we may disclose reasonably necessary PHI to law enforcement officials to identify or locate a suspect, fugitive, material witness or missing person.

- Use 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 authorities required by law 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 activates and national security/intelligence activities.

- Use and Disclosures 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-CHICAGO NEUROSCIENCE INSTITUTE, LTD. 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 Purpose-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 Chicago Neuroscience Institute, Ltd.? Chicago Neuroscience Institute, Ltd. must maintain the privacy of PHI, abide by the terms of this notice and provide patients with a revised notice, if necessary.

CHICAGO NEUROSCIENCE INSTITUTE

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

For use and/or disclosure of Protected Health Information (PHI)
To carry out Treatment, Payment and Healthcare Operations

_____, hereby states that by signing this Consent,
(Patient Name)

I acknowledge and agree as follows:

The CNI Practice Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my Protected Health Information (PHI) necessary for the Practice to provide treatment to me and also, necessary for the Practice to obtain payment for that treatment and to carry out health care operations. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

The practice reserves the right to change its privacy practices that are described in its Privacy Notice in accordance with the applicable law.

The Practice's Privacy Notice is provided at the time of the patient's first visit and is always available with the staff at the reception desk. I may also request a copy from this office at any time via US Mail.

This Notice of Privacy Practices also describes my rights and the duties of this office with respect to my Protected Health (PHI).

I have read and understand the forgoing notice and all of my questions have been answered to my complete satisfaction in a way that I can understand.

Name of Patient: _____ Date: _____

Signature: _____ Date: _____

Signature of Legal Guardian: _____ Date: _____

Witness: _____ Date: _____

1795 Grandstand Place, Elgin, IL 60123
Phone: (847) 888-1811 Fax: (847) 888-1868

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Private Health Insurance or Medicare Information	Patient Personal Injury Insurance Information
Policy Holders Name:_____ Social Security Number:_____ Insurance Companies Name:_____ Insurance Phone #:_____ Policy or Group #:_____ Medicare #:_____	Date of Injury:_____ Name of Insurance:_____ Address:_____ City:_____State:_____Zip:_____ Phone #:_____ Claim #:_____ Policy Holder:_____ Claim Adjuster:
Private Secondary Insurance Information	**Third Party Insurance Company Information**
Policy Holders Name:_____ Social Security Number:_____ Insurance Companies Name:_____ Insurance Phone #:_____ Policy or Group #:_____ Medicare #:_____	Name of Insurance Company:_____ Address:_____ City:_____State:_____Zip:_____ Phone #:_____ Claim #:_____ Policy Holder:_____ Claim Adjuster:
Name of Attorney: _____ **Address:**	**Phone: _____ Fax: _____** **Notes:**

WORKERS COMPENSATION

Date of Injury:_____ Insurance Company Name:_____ Address:_____ City:_____State:_____Zip:_____ Phone #:	Claim #:_____ Attn:_____ Employer at the time of injury:_____ Address:_____ City: State: Zip:

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with_____
Name of your Insurance Company

And assign directly to Chicago Neuroscience Institute, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for al charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Signature of Insured/Guardian: Date:

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Chicago Neuroscience Institute for any services furnished to me. I authorize any holder of medical information needed to determine these benefits of the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on the approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.5

Beneficiary Signature: Date:

CHICAGO NEUROSCIENCE INSTITUTE

Thank you for choosing Chicago Neuroscience Institute as your healthcare provider. Please understand that payment of your bill is considered part of your care. The following is a statement of our Financial Policy which we require you to read and sign prior to the provision of services.

FINANCIAL POLICY

All patients must complete our patient information packet in full prior to seeing a physician

PAYMENT IS DUE AT THE TIME OF SERVICE

We accept cash, check, and insurance, Visa or MasterCard

Financial assistance is available to those who qualify

Regarding Commercial Health Insurance:
Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We will accept assignment of insurance benefits with confirmed commercial insurance coverage with an insurance company who has maintained good credit with Chicago Neuroscience Institute. Chicago Neuroscience Institute submits claims to insurance carriers as a courtesy to our patients. It is the patient's responsibility to make sure that all services rendered are covered benefits. You are required to pay your co-pay, deductible and co-insurance portion at the time of each visit.

Workers Compensation:
If your condition is the result of a work related injury, we require that you have an authorization number and the name of the insurance adjuster; otherwise you will be required to pay for the initial visit in full at the time of service. If your workers compensation case is contested, we require payment in full at the time of services, or confirmation of commercial health insurance coverage or other liable 3rd party coverage. See above regarding commercial health insurance.

Automobile (Personal) Injuries:
If your condition is the result of an automobile accident, we will bill your automobile med pay insurance. If med pay is not available, we may submit the claims to your personal health carrier. If third party liability cannot be confirmed, we will require payment in full at the time the services are rendered.

Minors:
Parents and/or legal guardians are required to accompany a minor at the time services are rendered. For unaccompanied minors, non-emergency treatment will be denied.

Missed Appointments:
Scheduled appointments should be canceled at least 24 hours in advance. Our policy is to charge for missed appointments at the rate of $25. Please help us serve you and others by keeping scheduled appointments.

Regarding Billings:
I understand that I will receive a monthly bill reflecting the balance due. I also understand that I am responsible to pay any and all remaining balances within 60 days from the date services are rendered. Chicago Neuroscience Institute follows the current guidelines of HIPAA and of the Illinois Hospital Association regarding the setting of fees for health care handling and copying of patient's records. If my records are requested by a third party we will follow the guidelines set by HIPAA and the Illinois Hospital Association to determine our charges. I also understand that if legal and/or collection services are required on past due balance(s), after sixty (60) days from date of service, all costs including reasonable attorney's fees are my responsibility or that of the legal guardian in the case of a minor.

If we accept assignment from your insurance company, or any liable third party, we maintain the right to demand payment from you, the patient, if for any reason your balance has not been paid in full within sixty (60) days from the date of service.

I understand and agree to the terms of this Financial Policy:

Patient Signature / Legal Guardian Date

Witness Date