1010 Lake Street
Suite 400
Oak Park, IL. 60301

P: 312.801.0138

www.BHealthCares.com

info@bhealthcares.com

PATIENT REGISTRATION FORM

Last Name :	First Name :	Middle:	
Address:	City:	State:	Zip:
	DOB: (mm/dd/yyyy) / Age:	Gender:	
Home Phone :	Cell Phone :	Work Phone:	
E-Mail Address:	Preferred Method of Contact: ☐ Home ☐ Work ☐ E-Mail ☐ Cell		
Reason for Appointment:		Which Side of the Body? ☐ Left ☐ Right	Date Symptoms Began:

PHYSICIAN INFORMATION

Signing Physician :	Signing Physician Phone:		
Primary Care Physician:	Primary Care Phone:		
Address:	City :	State:	Zip:

REQUIRED IF LEAVING PHYSICIAN INFORMATION BLANK: I decline to provide the name of another treating healthcare professional or physician. SIGNATURE:

PLEASE SELECT WHAT SERVICE YOU ARE COMING IN FOR

PHYSICAL THERAPY ☐	CHIROPRACTIC ☐
HEALTH & NUTRITIONAL COACHING ☐	OTHER (PLEASE LIST) ☐

HOW DID YOU FIND OUT ABOUT FHG?

☐ *I am a Former Client*
☐ *Website*
☐ *Yelp*
☐ *Personal Trainer:*

☐ *Google*
☐ *Family/Friend*
- Recommendation Name:
____
☐ *Internet Search*

☐ *Doctor Recommendation*
☐ *Chiropractor Recommendation*
☐ *Special Event:*
☐ *Other:*

Patient/Guardian Signature: Date:

HEALTH
OPTIMIZING HEALTH
WELLNESS AND PERFORMANCE

OAK PARK
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Consent for Treatment

I voluntarily consent to receive treatment at B-Health. I permit its employees and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand that this care may include an evaluation, testing and treatment. No guarantees have been made to me about the outcome of this care. I hereby authorize B-Health to release information, verbal and written, contained in my medical record, and other related information to my insurance company, rehabilitation nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries, and all other related persons as it relates to my treatment and/or payment for services provided.

Patient/Guardian Signature ______________________________ Date _____________

Financial Responsibility

I understand that insurance coverage is not a guarantee of payment. I understand that I am ultimately responsible for services rendered by B-Health. I will honor the B-Health payment policy. All co-payments and patients that are self-pay are due in full at the time of service. Co-insurance and deductibles are the patient's responsibility. They will be invoiced once the Explanation of Benefits is provided by the patient's insurance carrier. Invoices are due 30 days after receipt. I authorize payments of benefits directly to B-Health for services provided. B-Health has the right to consult a collection agency if payment is past 90 days due. If any portion of the account balance exceeds 90 days the patient will be responsible for this amount plus interest of 1.5% per month, unless otherwise noted. I understand that I am financially responsible for payment of all services that are not paid by my insurance carrier. Should my account be referred to collection, I will be responsible to pay reasonable cost of collections including attorney fees. If I choose to be a self-pay patient I understand the fees are as agreed upon between myself and B-Health.

Patient/Guardian Signature ______________________________ Date _____________

Cancellation Policy

B-Health prides itself on providing its patients with a dedicated appointment time to meet your physical therapy needs and fit your schedule. Therefore, you agree to provide us at least 24 hours advance notice prior to your scheduled appointment time if you are unable to attend. If you do not cancel at least 24 hours in advance of your appointment time you will be responsible for paying a $75 fee for your first late cancellation and $125 for every late cancellation thereafter. If you fail to provide any notice of being unable to attend and do not show up, you will be responsible for paying a $125 no show fee. B-Health reserves the right to reschedule an appointment as necessary upon reasonable notice to the patient.

Patient/Guardian Signature ______________________________ Date _____________

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INSURED PATIENTS

HEALTH INSURANCE   Please provide your insurance card.

PRIMARY INSURANCE ______________________________ ID#_________________ GROUP # ________________

If you are not the primary holder on your insurance policy, provide info below.

Guarantor's Name (as listed on card) _____________________________________ Birth Date ____________________

SECONDARY INSURANCE ______________________________ ID#_________________ GROUP # _____________

If you are not the primary holder on your insurance policy, provide info below.

Guarantor's Name (as listed on card) _____________________________________ Birth Date ___________________

B-Health can bill for both IN and OUT of network plans. B-Health is currently In Network with Blue Cross/Blue Shield, Aetna, Cigna, Humana, and United Health Care.

Insurance cards are required at every visit. We will verify your insurance coverage at the time of your first visit. Depending on your insurance, B-Health will be reimbursed based on a percentage of the amount billed. We do not know the exact amount until we receive payment. All co-payments, deductibles, and payments for non-covered services (nutrition, homeopathy, and herbs) are due at the time of service.

As the recipient of services from B-Health, you are ultimately responsible for all services provided. Our office will submit one (1) claim to your Health Insurance Provider. B-Health is under no obligation to pursue reimbursement on the patient's behalf other than the one-time submission of the claim. If payment from your Insurance Provider is not received in full within thirty (30) days after submission of the request for payment, a courtesy letter will be written to your attention notifying you that your bill has not been paid. It is thereafter your responsibility to ensure that your health insurance pays your bill for services. If payment is not received in full within sixty (60) days, by providing your card and receiving provided services, you are authorizing B-Health to charge your provided credit card for any unpaid bills or claims. Without a card on file, payment is due in full at the time services are rendered. Any claims paid after your credit card has been billed will be refunded to the patient.

It is not the responsibility of B-Health to continually track your coverage. If there is a lapse in your coverage or you have maxed out your coverage, you are responsible for payment in full of the billed amount. If there are any changes to your insurance including, but not limited to, new insurance member identification number and/or group number, please inform the office. Not updating your personal information can delay and/or deny your insurance claims. If you have not provided our office with the correct insurance information, you will be responsible for any balance due. Please understand that your insurance is an agreement between you and your insurance company, and all services rendered to you are ultimately your responsibility.

ASSIGNMENT OF BENEFITS TO DOCTOR

In considering the amount of medical expenses to be incurred I, the undersigned, have insurance and/or employee health care benefits coverage with the above mentioned Health Insurance Provider, and hereby assign and convey directly to Fuller Health Group, PC all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments.

Patient/Guardian Signature: ____ Date ______________________

PRINT FILL OUT FAX to 708-221-7108
& bring to your appointment.

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PATIENT MEDICAL HISTORY

Name: ______________________________

Diagnosis/Body part(s) you are being referred for:

____

Dates Symptoms Began: ____________________

Please Check: ☐Work Injury ☐Motor Vehicle Accident ☐Other ____________________

Did this injury require surgery? ☐Yes ☐No

Kind of surgery and Date: ____________________

Are you taking any medications for this injury?

☐Yes ☐No

Please list all Medications:

____

____

Please check your PRE-INJURY level of function below:

☐0% ☐10% ☐20% ☐30% ☐40% ☐50%

☐60% ☐70% ☐80% ☐90% ☐100%

Please ccheck your CURRENT level of function below:

☐0% ☐10% ☐20% ☐30% ☐40% ☐50%

☐60% ☐70% ☐80% ☐90% ☐100%

Please describe the location of your pain:

____

Please indicate which of these words, if any, describe your pain. Check all that apply:

☐Aching ☐Shooting
☐Burning ☐Throbbing
☐Sharp ☐Tingling

Rate your pain intensity on a scale of 0-10 (0 being no pain):
Current pain ___ /10 At Best ___ /10 At Worst ___ /10

Which activities increase your symptoms? Check all that apply:

☐Bending ☐Reaching ☐Squatting ☐Twisting
☐Driving ☐Reclining ☐Walking
☐Kneeling ☐Rising ☐Stairs
☐Lifting ☐Sitting ☐Standing
☐Other ____________

What eases your symptoms?
☐Moist Heat ☐Ice Application ☐Medication
☐Rest ☐Change in position ☐Other

Normal Physical Work Activities:

____

____

Is your condition overall:

☐ Improving ☐Getting Worse ☐Staying the same

Have you had any treatment of this current problem in the past?

☐Yes ☐No

Have you received any of the following tests for this problem?

☐X-rays ☐CT Scan ☐Bone Scan

☐MRI ☐EMG ☐Nerve Conduction Study

☐Other ______________________________

Medical History Information: If you have/had any of the following conditions, please check and give approximate dates or indicate current. If it does not apply, please write N/A.

☐Arthritis ____________________
☐Asthma ____________________
☐Blood Pressure Problems ____________________
☐Broken Bones ____________________
☐Convulsions ____________________
☐Diabetes ____________________
☐Disabling Headaches ____________________
☐Disc Trouble ____________________
☐Fainting Spells ____________________
☐Heart Problems ____________________
☐Osteoporosis ____________________
☐Pacemaker Implantation ____________________
☐Paralysis or Muscle Weakness ____________________
☐Pregnancy ____________________
☐Spine Issues ____________________
☐Tumor or Cancer ____________________
☐Other ____________________

Please list ALL previous surgeries and the year performed regardless of body part:

____

____

____

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MEDICAL RECORD PRIVACY INFORMATION

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.

Our Policy on Medical Record Privacy
This notice will describe the way our practice will treat the medical records we keep regarding your medical care. We are required to keep a record of your care including the diagnosis treatment services you receive and other information. We are required by law to protect your personal medical record by keeping it private and following certain rules that dictate whether and when we can use or disclose your information. This notice will inform you of these rules. It will also notify you of your rights and our obligations in our use and disclosure of your health information. We are also required to give you notice and to follow the terms of the notice that is currently in effect. We reserve the right to change this notice and apply those changes to the health information we currently have as well as information we may receive in the future. If we change this notice you will receive a new copy of this notice the next time you receive services from our practice. A copy of this notice will be on display in our office.

Understanding Your Health Record

Each time you visit B-Health, a record of your visit is made. Typically this contains your symptoms, examination, test results, diagnosis, treatment, and a plan for future care of treatment. This information, often referred to as your health or medical record, may serve as a:

- Basis for planning you care and treatment
- Legal document describing the care you received
- Means by which you or a third party payer (such as your insurance company or HMO) can verify that services billed were actually provided
- A source of data for medical research
- A source of information for public health officials charged with improving the health of Illinois and the nation
- A source of data for planning and marketing
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

You Have Rights Regarding Your Health Information

You have the right to:

- Request that we restrict the use or disclosure of your health information for treatment, payment, or healthcare operations (as described in this notice)
- Request that we restrict from disclosing information to family or friends
- Request how you would like us to communicate with you
- Inspect and copy certain health information, including most of your medical and billing records. This request must be made in writing to the Privacy Officer. A reasonable fee may be applied for copying, postage, or other expenses related to your request. We may deny your request to inspect and or copy your health information. If we do, another licensed health care professional will review your request and we will comply with the outcome of the review.
- Amend your health record as provided in 45 CFR 164,528
- Obtain an accounting of disclosure of your health information as provided in 45 CFR 164,528
- Obtain a paper copy of this notice upon request

NOTE:

We are not required to agree to your requests. To request restrictions or limitations, you must make a written request to the Privacy Officer. The request must tell us (1) what information you want to limit; (2) whether you want to limit the use of the information and or disclosure of the information; (3) to whom the limitation or restriction will apply.

B-Health is required to :

- Maintain the privacy of your health information
- Provide you with this notice as to our legal duties and privacy practices with respect to the information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we were unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

For More Information or to Report a Problem

If you have questions and would like additional information you may contact the practice's Privacy Officer at 312-801-0318. If you believe your privacy rights have been violated you can file a complaint with the practice's Privacy Officer or with the Office of Civil Rights U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office of Civil Rights.

The address for the OCR is listed below:
Office of Civil Rights U.S. Department of Health and Human Services
Independence Avenue S.W.
Room F HHH Building
Washington D.C.

How We May Use and Disclose Your Health Information

We may use and disclose your health information for a number of purposes in connection with your medical care and in running our practice. The following lists a number of typical uses and disclosure within our practice. We will use your health information for the following:
Treatment

We may use your health information to diagnose your illness or injury provide you with services or refer you to another physician. We may disclose your health information to doctors nurses technicians medical students or other personnel who are involved with your care. We also may disclose your health information to people outside of our medical practice who may be involved in medical care such as family members clergy or others.

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Payment
We may give your health plan information regarding your diagnosis and treatment in order to be paid for your office visits, procedures, x-rays, or laboratory work. We may also provide information to determine whether your health plan pays for medical care you need, and whether we need to get authorization from the health plan before treating you.

Health Care Operations
We may use or disclose your information if we conduct quality assessment and improvement activities to ensure that our patients receive quality medical care. We may also use or disclose your information in training and evaluation of our physicians and other staff, or as part of a medical review, audit, or legal activities.

Appointment Reminders
We may use or disclose your information to contact you as a reminder that you have an appointment with our practice.

Individuals Involved in Your Care or Payment for Your Care
We may disclose your health information to a family member or friend who is involved in your medical care or who helps pay for your care. We may also tell your family or friends about your condition, for example, if you are admitted to the hospital or in the event of a disaster relief effort.

Public Health Risk
We may disclose your health information to report disease, injury or disability ; births and deaths; child abuse or neglect ; defects, recalls or problems with drugs, medical devices, or other products; to prevent or conditions. We may also notify authorities if we believe you have been the victim of abuse, neglect or domestic violence, if we are required by law to do so, or if you agree to the notification.

Health Oversight Activities
We may also disclose your health information to agencies authorized by law for audits, investigations, inspections, and licensure.

Law Enforcement
We may disclose your health information when the following circumstances apply:

- If you have incurred certain injuries or wounds that are legally required to be reported;
- In response to a court order, subpoena, warrant, summons, Investigative demands, or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if under certain limited circumstances;
- About a suspicious death that we believe may be the result of criminal conduct;
- About criminal conduct on our premises;
- In emergency circumstances to report a crime, its location, or information about the person who may have committed the crime.

Coroners, Medical Examiners, and Funeral Directors As necessary to carry out their duties.

Specialized Government Functions
We may disclose your health information to release information to military command authorities, upon you separation or discharge from military service to authorized officials. We may also disclose your health information to the appropriate government officials when it is neces-sary to conduct intelligence or other national security activities authorized by federal law. In addition, we may release your health information if it relates to the protection of the Presidents of the United States or foreign heads of state. Finally, we may disclose certain information related to members of the armed services and foreign military services to the appropriate personnel.

Inmates
If you are an inmate of a correctional facility or under the custody of a law enforcement official, we may disclose your health information to the correctional institution or law enforcement official in order to provide you with medical services, protect you or others, or to ensure safety of the correctional facility.

Workers' Compensation for Work Related Illness or Injuries
We may disclose your health information in relation to workers' compensation or similar programs established by law that provides benefits for work-related illness or injuries.

Other Uses of Your Health Information
We may disclose your health information when required by federal, state or local law, for treatment alternatives or health related benefits/ services, organ and tissue donations, or to avert a serious threat to health or safety.

ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I received the Notice of Privacy Practices of B-Health

______________________________ ________
Patient / Parent or Guardian Signature Date

____
Patient / Parent or Guardian Printed Name

Office Use Only:

______________________________ ________
Witness Date