South Chicago Orthopedic Specialists, S.C.
1701 W Monterey Avenue
Suite 4
Chicago, IL 60643
Phone: 872-228-0235
Fax: 773-530-0520

Steven A. Chandler, D.O.

SCOS
South Chicago Orthopedic Specialists, S.C.

Patient Registration Form

Name: _____ **Today's Date:** _____

Social Security #: _____ **Date of Birth:** _____ **Age**: _____

Sex: M or F (Circle One) **Handed**: O Right O Left O Ambidextrous

MAILING ADDRESS: _____
Street or Box Number

_____
City, State, Zip

Please check your primary phone

O CELL PHONE: _____

O HOME PHONE: _____

O OTHER PHONE: _____

EMAIL: _____

PRIMARY CARE PHYSICIAN (PCP) CONTACT INFORMATION

PCP Full Name: _____
PCP Address: _____
PCP Phone Number: _____

EMERGENCY CONTACT INFORMATION

Name/Relation: _____
Address: _____
Phone: _____

INJURY: O Yes O No If yes, complete the following:

HOW DID IT HAPPEN? _____

_____

Current problem is the result of a(n): Check all that apply

O Car Accident O Work Accident O Accident O Other _____

ATTORNEY NAME & PHONE IF LEGAL CASE IS INVOLVED WITH INJURY: _____

CLAIM #: _____ DATE OF INJURY: _____ ADJUSTER NAME & PHONE: _____

EMPLOYER'S WORKER'S COMPENSATION INSURANCE CARRIER: _____

ADDRESS COMPENSATION INSURANCE CARRIER: _____
Street or Box Number City State Zip

RACE
- O Caucasian
- O Black
- O Asian
- O Native American
- O Native Hawaiian
- O Other Polynesian
- O More than One (1) Race
- O Decline to Specify

ETHNICITY
- O Hispanic
- O Non - Hispanic
- O Decline to Specify

MARITAL STATUS
- O Married
- O Single
- O Divorced
- O Widowed
- O Legally Separated

EDUCATION LEVEL
- O Less than High School
- O High School Diploma
- O GED
- O Some College
- O College Degree

OCCUPATION
- O Student
- O Work in the Home
- O Employed Occupation_____
- O Daycare
- O Retired

PREFERRED PHARMACY NAME: _____

_____
Address Phone

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Name: _____ **Height**: _____ **Weight**: _____
(Required) (Required)

Why are you seeing the doctor today? _____

CURRENT MEDICATIONS: Medication List attached O Yes O No

Medication	Dose	Reason for Medication	Medication	Dose	Reason for Medication
_____			_____		
_____			_____		

MEDICATION ALLERGIES:

_____ Side Effect(s)_____

_____ Side Effect(s)_____

Are you currently having or have you had problems with:

Please circle your response and describe all YES Answers

PAST MEDICAL HISTORY

Asthma	No Yes	_____
Heart Problems	No Yes	_____
Stroke/TIA	No Yes	_____
GERD/Acid Reflux	No Yes	_____
GI Ulcers	No Yes	_____
Epilepsy	No Yes	_____
Stool Blood Red/Black	No Yes	_____
Urinary Tract Infections	No Yes	_____
Anemia	No Yes	_____
Diabetes	No Yes	_____
High blood pressure	No Yes	_____
Psychological Problems	No Yes	_____
AIDS/HIV	No Yes	_____
Cancer	No Yes	_____
Arthritis	No Yes	_____
Polio	No Yes	_____
TB	No Yes	_____
Other		_____
Other		_____
Other		_____
Other		_____
Other		_____
Other		_____

REVIEW OF SYSTEMS

Tiredness/Fatigue	No Yes	_____
Instability	No Yes	_____
Fever	No Yes	_____
Chills	No Yes	_____
Night Sweats	No Yes	_____
Weight Loss/Gain	No Yes	_____
Skin Lesions/Ulcer	No Yes	_____
Ears, Nose, Throat	No Yes	_____
Heartburn	No Yes	_____
Wheezing	No Yes	_____
Short of Breath	No Yes	_____
Chest Pain	No Yes	_____
Joint Problems	No Yes	_____
Muscle Problems/Pain	No Yes	_____
Swelling	No Yes	_____
Redness	No Yes	_____
Stiffness	No Yes	_____
Deformities	No Yes	_____
Back Pain	No Yes	_____
Pain Down Back of Legs	No Yes	_____
Paralysis/Weak Limbs	No Yes	_____
Nail Changes	No Yes	_____
Loss of Balance	No Yes	_____
Numbness/Tingling	No Yes	_____
Change of Skin Color	No Yes	_____
Blackout/Fainting	No Yes	_____
Pain	No Yes	_____
Bleeding problems	No Yes	_____

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Surgeries/Hospitalizations	**Treating/Doctor**	**Year**	**Complications**

Have you ever had general anesthesia? No Yes _____
Have any problems with anesthesia? No Yes _____ Describe _____

FAMILY HISTORY:

Member	Alive	Deceased	Age	Health status or cause of death
Father	A	D	_____	_____
Mother	A	D	_____	_____
Sister/Brother	A	D	_____	_____
Sister/Brother	A	D	_____	_____
Sister/Brother	A	D	_____	_____

SOCIAL HISTORY:

Do you have children? O No O Yes #_____
Do you live alone? O No O Yes
Do you exercise? O Daily O Weekly O Monthly O Rarely O Never
What type of exercise? _____
History of substance abuse? O No O Yes What? _____
Do you smoke currently? O No O Yes _____ Packs per day for ____ years
Have you quit smoking? O This year O >1 year O >5 years O >10 years
Have you previously smoked? O No O Yes ____ packs per day for _____ years
Do you drink alcohol? O Daily O 1-2 x/week O 1-2 x/month O 1-2 x/year

Patient Signature: _____ **Date:** _____

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AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS

I hereby give lifetime authorization for payment of insurance benefits to be made directly to South Chicago Orthopedic Specialists and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits.

CONSENT TO OBTAIN ELECTRONIC MEDICATION HISTORY

By signature of this form I consent to allow the healthcare provider(s) at South Chicago Orthopedic Specialists to download my electronic medication history from all healthcare provider(s) as is necessary for my care and treatment. I understand I may opt out of this provision by initialing and dating here: ***Initials***: _____ ***Date***: _____

SOUTH CHICAGO ORTHOPEDIC SPECIALISTS FINANCIAL POLICIES

The Service We Provide

Our physicians, doctors, physician assistants, therapists and technical staff provide professional medical and radiology services as well as supplies required by your orthopedic medical needs. The bill from South Chicago Orthopedic Specialists is for these services ***only***. Services provided by the laboratory, pathologist, anesthesiologist, medical equipment supplier, and in some instances your assistant surgeon will be billed separately from our services. Consistent with our Privacy Practices we will give your billing information to these providers. Please direct any questions you have about these services to the appropriate provider's office. Our staff can assist you if you need to contact these providers. We will bill your insurance company for the services we render. To provide excellent service it is necessary that we have accurate information about you, your employer and your insurance. We will ask you to complete health questionnaires and consent for use and disclosure of information. We will also need to take copies of your insurance card(s). These items will be necessary for your treatment and to receive payment for our services. Please, notify us immediately when there are changes to the information you have provided.

Medicare

South Chicago Orthopedic Specialists are Medicare Participating Providers. As a Participating Provider we will bill Medicare directly for you and will honor Medicare's "allowance". We will also bill your secondary insurance if you have provided us with the information. You will be required to pay only the amount Medicare determines to be your responsibility that is not paid by your secondary insurance. We will send you a statement that will detail all charge and payment activity.

Illinois Department of Public Aid

South Chicago Orthopedic Specialists participate in the IDPA Program as well as Managed Medicaid through Managed Care Organizations (MCOs). As a IDPA Provider we will bill IDPA directly and accept IDPA's "allowance". You will be responsible to pay any copays or spend-downs determined by IDPA to be your "Share Of Cost". To comply with the IDPA program requirements it is necessary that your share of cost be paid at the time the service is rendered.

PPO, Indemnity Insurance and HMO Plan

South Chicago Orthopedic Specialists are participating providers for many insurance plans. To ensure that your insurance benefits are maximized we will verify eligibility and estimate benefits of your insurance from the information you provide us. Prior to your surgery we will notify you of the eligibility and benefit results.

Any deductible, co-payment and co-insurance amounts are to be paid prior to your surgery. These amounts are estimated during the eligibility and benefit verification process. Actual benefits can only be determined when your insurance company processes your bill. You will be promptly refunded in the event you have over paid; conversely you are obligated to pay any balance. We will send you a statement that details all charge and payment activity. Should your insurance company not pay within forty-five days of your surgery, we may seek payment from you. Please assist us by communicating with your insurance company to ensure that their financial obligation is met.

Worker's Compensation Insurance

South Chicago Orthopedic Specialists accept Worker's Compensation. It is necessary that you provide us accurate information about you, your injury, your employer and your Workers Compensation carrier. Prior to your service we will obtain your claim number and pre-authorization from your Workers Compensation carrier. You will not receive a bill for these services unless your claim is denied as "not work related". In these instances, your private insurance company should pay for South Chicago Orthopedic Specialists services.

Uninsured

You are personally responsible for to pay for our services if you do not have insurance. Full payment is required prior to your service. Any arrangement for payment must be established prior to service. We do offer services that can help you finance the cost of your treatment.

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Forms Completion Fee
South Chicago Orthopedic Specialists patients in some instances may require insurance or disability forms to be completed by us. South Chicago Orthopedic Specialists has a form completion fee of $5.00 per page; a double sided page is considered two pages, with a minimum charge of $15.00. All forms shall be completed within seven (7) business days of receipt of your payment. In the event medical records are required in electronic form or paper form, any applicable record production fees will be charged in addition to the form completion fee.

Canceled or Missed Appointments
South Chicago Orthopedic Specialists are committed to providing care to all of our patients in a timely manner. To assist us, we ask that you make every effort to keep your scheduled appointment and contact us as soon as possible when you are unable to do so. Appointments canceled or missed without notice are subject to a Canceled or Missed Appointment fee which will not be billed to your insurance and will be your personal responsibility to pay. The following are appointment types and notice requirements that must be met to avoid a Canceled or "No-Show" Appointment Charge:

Appointment Type	Notice Required	Cancelled or "No Show" Appointment Charge
Office Visits/Consultation	1 full business day	$35.00
Injections and Surgeries	5 full business days	$150.00

Non-Sufficient Funds, Canceled or Return Checks
South Chicago Orthopedic Specialists will assess a fee of $25.00 for each non-sufficient fund transaction, canceled, or returned check.

NOTICE OF PRIVACY PRACTICES
Protecting the privacy of your health information is important to us at South Chicago Orthopedic Specialists. A *Notice of Privacy Practices* form is available to review upon your request. This notice explains the federal HIPAA Privacy Rule which is designed to help protect the privacy of your health information. It also details how we may legally use your medical or health information. Your signature on this form acknowledges that you were offered a copy of the Notice of Privacy Practices. If you have any questions about the HIPPA Privacy Rule please contact the Practice Manager, HIPAA Compliance Officer.

My signature acknowledges that I have read and agree to the following:

- Notice of Privacy Practices
- Release of Health Information and Assignment of Insurance Benefits
- Access to my medication history
- Terms of the South Chicago Orthopedic Specialists Financial Policy

Signature of Patient or Legal Guardian if Patient is a Minor **Date**

Name of Patient or Legal Guardian (Print)

Name of Authorized Representative (Print) **Relationship**

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Notice of HIPAA Privacy Practices

The HIPAA Privacy Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information in some cases.

Your "protected health information" means any written and verbal health information about you, including demographic data that can be used to identify you.

You will be given a copy of our HIPAA Privacy Notice prior to your visit, and be asked to sign that you received it.

This notice advises you about the ways in which we may use and disclose your Protected Health

Information (PHI). Protected Health Information (PHI) means any of your health information that could be used to identify you and that results to you past, present, future physical or mental health or condition and related health care services. It also describes your rights and our duties with respect to your PHI. The law requires us to provide a copy of this notice to you which explains our legal duties and privacy practices.

My Signature acknowledges that I have been offered a copy of South Chicago Orthopedic Specialists Notice of Privacy Practices at the time of registration.

Patient Signature:_____ **Date:**_____