Patient Registration Form

MRN# _____ (office use only)

First Name: _____ Last Name: _____ Date of Birth: ____/____/____

Address: _____ City, State, Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Emergency Contact Name: _____ Phone: _____ Relation: _____

How did you hear about Chebny Sports Medicine? ☐Physician ☐Friend/Relative ☐Website ☐Insurance Company ☐Facebook ☐School ☐Other:_____

Have you had Physical or Occupational Therapy elsewhere this year?	Yes	No
Is your injury work related?	Yes	No
Have you been injured as a result of a fall in the past year?	Yes	No
Have you had 2 or more falls in the last year?	Yes	No
Are you currently receiving home health care?	Yes	No

Employees at Chebny Sports Medicine gather weekly to pray for our patients. Would you like Chebny Sports Medicine to pray for you and your recovery? ☐ Yes ☐ No

Medical History (Please circle **Yes** or **No**)

Allergies	Yes	No	Hepatitis	Yes	No
Anemia	Yes	No	High Cholesterol	Yes	No
Anxiety	Yes	No	High/Low Blood Pressure	Yes	No
Arthritis	Yes	No	HIV/AIDS	Yes	No
Asthma	Yes	No	Incontinence	Yes	No
Auto Immune Disorder	Yes	No	Kidney Problems	Yes	No
Cancer	Yes	No	Metal Implants	Yes	No
Cardiac Conditions	Yes	No	MRSA	Yes	No
Cardiac Pacemaker	Yes	No	Multiple Sclerosis	Yes	No
Chemical Dependency	Yes	No	Muscular Disease	Yes	No
Circulation Problems	Yes	No	Osteoporosis	Yes	No
Currently Pregnant	Yes	No	Parkinson's	Yes	No
Depression	Yes	No	Rheumatoid Arthritis	Yes	No
Diabetes	Yes	No	Seizures	Yes	No
Dizzy Spells	Yes	No	Smoking	Yes	No
Emphysema/Bronchitis	Yes	No	Speech Problems	Yes	No
Fibromyalgia	Yes	No	Strokes	Yes	No
Fractures	Yes	No	Thyroid Disease	Yes	No
Gallbladder Problems	Yes	No	Tuberculosis	Yes	No
Headaches	Yes	No	Vision Problems	Yes	No
Hearing Impairment	Yes	No			

Rev. 12/19

Chebny SPORTS MEDICINE

MRN# _____ (office use only)

Please describe any other conditions not listed on the previous page: _____

_____

List any allergies (if applicable): _____

_____

Surgical History Please list surgeries (if applicable).

Body Region	Surgery Type	Month/Year

Current Medications Please list medication (if applicable) or provide a medication list.

Medication	Dosage	Frequency	Reason for Taking

Patient Signature/Representative: _____ Date: _____

Printed Name: _____ Relationship: _____

MRN# _____ (office use only)

Consent to Evaluate and Treat

I _____and/or _____

Patient Name Legal Guardian/Representative (if applicable)

hereby consent to such medical evaluation and/or treatment as necessary and appropriate for my condition, based on the judgement of my Physical Therapist and/or other health care provider(s).

Patient Signature: _____ Date: _____

Signature of Legal Guardian/Representative: _____Date: _____

Relationship of Legal Guardian/Representative: _____

Notice of Privacy Practice (NPP)

The notice describes how medical information about you may be used or disclosed, and outlines your rights, your choices, and our responsibilities as a health care provider.

Chebny Sports Medicine LLC makes available the Notice of Privacy Practices on its website at www.chebnysportsmedicine.com as well as via hardcopy in the office.

Please confirm receipt of the NPP by initialing here: _____

Disclosure of Medical and/or Financial Information

I am providing authorization to the staff of Chebny Sports Medicine LLC to discuss my medical and/or financial information to the following person(s) below:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

I understand that I must inform Chebny Sports Medicine LLC if there are any changes to this authorization.

Patient Signature: _____ Date: _____

Personal Items

I assume full responsibility for all my personal items brought into Chebny Sports Medicine LLC and will not hold Chebny Sports Medicine LLC liable for lost or damaged property. **Initial here: _____**

Note: The above authorizations expire one year from the date of signature.

Financial Policy

Patient Name: _____ MRN: _____ (office use only)

Authorized Representative: _____ Relationship: _____

Thank you for choosing Chebny Sports Medicine as your physical therapy provider. Please review our financial policy outlined below. If you have any billing questions, please call us at 224-252-2999.

- All co-payments, co-insurances, and deductible amounts are due at the time of service.
- Full payment is due at the time of service for all self-pay services.
- We must have a copy of your current insurance card, otherwise, you will be directly billed.
- Notification of any changes to your insurance policy is required immediately.
- It is your responsibility to verify we are an in-network provider for your insurance plan.
- It is your responsibility to submit any additional information requested from your insurance company or Chebny Sports Medicine to guarantee payment for services rendered.
- If you are here for a workers' compensation claim, additionally, we will need your health insurance information and will only bill that insurance if we do not receive proper documentation and/or payment from your workers' compensation carrier.

By signing this financial policy, you (the patient) or guarantor agree to pay Chebny Sports Medicine LLC for all services or supplies provided to you, including any co-payments, deductibles, co-insurance or other charges. Furthermore, you certify that the information provided by you for purposes of payment is, to the best of your knowledge, complete and accurate. I understand that I am ultimately responsible for payment of all services provided.

Patient Signature: _____ Date: _____

Authorized Representative: _____ Date: _____

Note: To accommodate all of our patients, Chebny Sports Medicine requires a **24-hour notice for cancellation.** Failure to comply may result in a $40 cancellation/no-show fee.

Please confirm your understanding of this policy by initialing here: _____

Chebny SPORTS MEDICINE

Notice of Privacy Practice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information**. Please review it carefully.**

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

Ask us to limit what we use or share	• You can ask us not to use or share certain health information for treatment, payment, or our operations.
	  • We are not required to agree to your request, and we may say "no" if it would affect your care.
	• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
	  • We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.

Your Rights *continued*

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 4.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory
- Contact you for fundraising efforts

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Chebny SPORTS MEDICINE

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	*Example: A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	*Example: We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	*Example: We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

Effective: 07/03/2017

This Notice of Privacy Practices applies to the following organization.

Chebny Sports Medicine| LLC. | 31 S. Seymour Avenue, Suite H, Grayslake, Illinois 60030

Phone: 224-252-2999 Website: www.chebnysportsmedicine.com

Questions and Complaints

If you want more information about our privacy practices, or have questions or concerns, please contact our Privacy Officer below.

JoAnn Chebny

31 S. Seymour Avenue, Suite H, Grayslake, Illinois 60030
Phone: 224-252-2999
Email:frontdesk@chebnysportsmedicine.com