BARRINGTON
Orthopedic Specialists
Specializing in You

HISTORY OF PRESENT ILLNESS

Patient Name: _____ **Date of Birth:** _____

Height: _____ Weight: _____ Shoe Size: _____ Hand Dominance: Right Left Ambidextrous

Family Physician: _____ Phone: _____

Address: _____

Referring Physician: _____ Phone: _____

Address: _____

For what part(s) of your body are you seeing the doctor today? _____

What was the date of injury, or when did your symptoms start? _____

Please describe the injury or how the injury started: _____

_____

_____

Please check any of the following symptoms that you have:

☐ Pain	☐ Stiffness	☐ Night Awakenings	☐ Instability	☐ Swelling
☐ Tingling	☐ Numbness	☐ Burning	☐ Popping	☐ Catching
☐ Locking	☐ Deformity	☐ Bow legged	☐ Knock-kneed	☐ Clicking
☐ Incontinence	☐ Limp	☐ Other Example:		

What activities, movements, or treatments have made your pain better? _____

_____

What activities, movements, or treatments have made your pain worse? _____

_____

Have you had any previous surgeries or hospitalizations for this condition? _____

_____

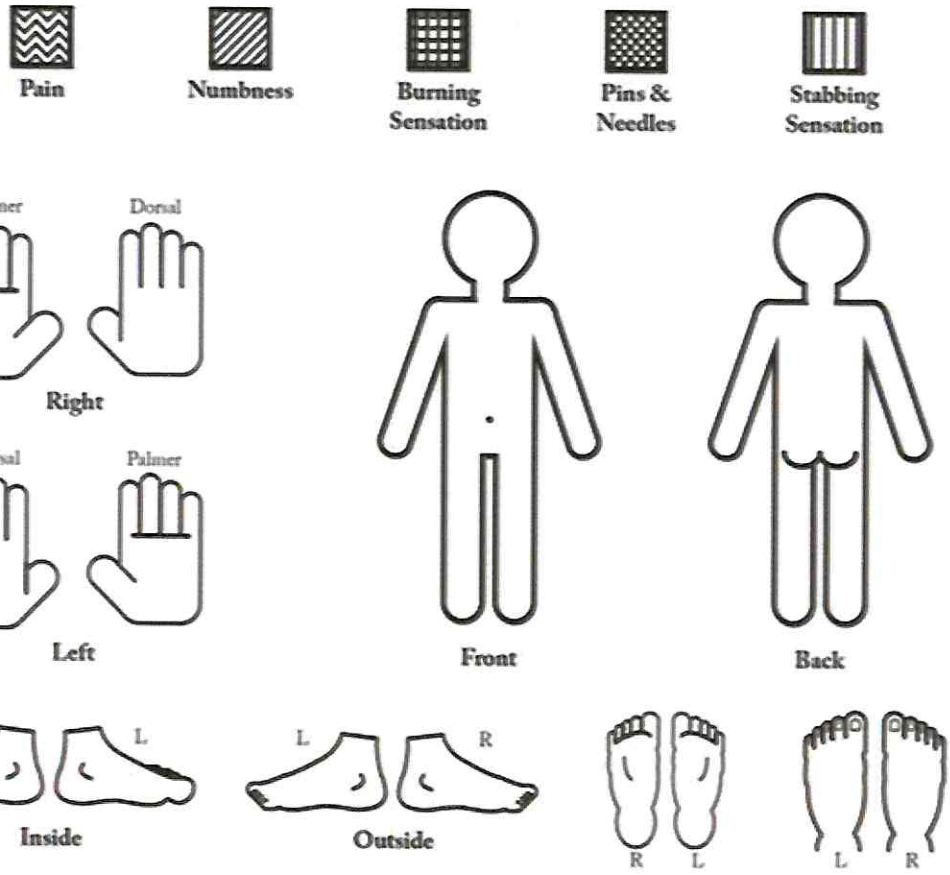
Did the injury happen at work?	☐ Yes	☐ No
If yes, have you filed a Workers' Compensation Claim?	☐ Yes	☐ No
Did the injury happen in a motor vehicle accident?	☐ Yes	☐ No

BARRINGTON
Orthopedic Specialists
Specializing in You

HISTORY OF PRESENT ILLNESS (2)

Preferred Pharmacy Name: _____ Town of Pharmacy: _____
Pharmacy Street/Intersection: _____ Phone Number: _____

Mark the appropriate area on the diagram where you feel the described sensation.



I have reviewed the above information and confirm that it is current and correct to my knowledge.

Signature: _____ Date: _____

BARRINGTON
Orthopedic Specialists
Specializing in You

PATIENT MEDICAL HISTORY

Patient Name:_____ **DOB:**_____

MEDICATIONS ☐ See attached list

Name of medication	Dose	Frequency

☐ More medications listed on back side

ALLERGIES ☐ No known drug allergies

☐ Penicillin ☐ Iodine ☐ Morphine ☐ Codeine ☐ Sulfa ☐ Amoxicillin ☐ Aspirin

☐ Food/environmental allergies (list)_____

☐ Other allergies (list)_____

MEDICAL HISTORY

Please list or check any of the following conditions you have had, particularly in the past 10 years

☐ Diabetes ☐ Arthritis ☐ Coronary Artery Disease ☐ High/Low Blood Pressure ☐ Reflux
☐ Ulcers ☐ Thyroid ☐ Heart Problems ☐ Kidney Disease ☐ Cancer
☐ Cholesterol problem ☐ Infectious problem ☐ Rheumatoid Arthritis ☐ Gout
☐ Breathing problems ☐ Liver disease ☐ Circulation problems ☐ Strokes
☐ Bleeding disorder ☐ Problems with anesthesia:_____
☐ Autoimmune disorder ☐ Neurological condition:_____

☐ Other:_____

BARRINGTON
Orthopedic Specialists
Specializing in You

PATIENT MEDICAL HISTORY(2)

FAMILY HISTORY

Please check all conditions that are in your family history:

☐ Diabetes ☐ Osteoarthritis ☐ Cancer ☐ Coronary artery disease ☐ Heart problems
☐ Gout ☐ Problems with anesthesia ☐ Autoimmune disorder ☐ Rheumatoid arthritis
☐ Bleeding disorder ☐ High blood pressure ☐ Other:_____

SURGICAL HISTORY

Please list all surgeries you have had, from birth to current:

Name of Surgical Procedure	Approximate Date of Surgery

ADDITIONAL MEDICATIONS

Name of medication	Dose	Frequency

BARRINGTON
Orthopedic Specialists
Specializing in You

PATIENT MEDICAL HISTORY(3)

SOCIAL HISTORY

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Living w/Significant Other

Patient lives with (minor): ☐ Parents ☐ Father ☐ Mother ☐ Grandparents ☐ Siblings

Current smoking status: ☐ Never smoker ☐ Former smoker ☐ Current Smoker every day ☐ Current Smoker some days

If you smoke, please indicate how much (packs per day or week): _____

If you use or used tobacco, for how many years? _____

If you are a former smoker, how many years ago did you quit? _____

Current smokeless tobacco status: ☐ Never user ☐ Former user ☐ Current user

Current E-cigarette/vape status: ☐ Never user ☐ Former user ☐ Current snuff user ☐ Current chewing tobacco user

Alcohol consumption level: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

If you are 65 years or older: do you have a medical power of attorney? ☐ YES ☐ NO

If you are 65 years or older, do you have an Advance Directive? ☐ YES ☐ NO

This is a living will or health care proxy – a legal document explaining how you want medical decisions about you to be made if you cannot make the decisions yourself.

Females ages 65 and older: If you have you ever had a DEXA or Bone Scan, write the date of DEXA/Bone Scan (write the approximate date month/day/year) _____

What is your current employment status: ☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Retired ☐ Student

Who is your current employer? _____

What is your current occupation? _____

What sporting activities do you perform? _____

I have reviewed the above information and confirm that is it current and correct to my knowledge. (v.02.22)

Signature:_____ **Date:**_____

BARRINGTON
Orthopedic Specialists
Specializing in You

HIPAA / RELEASE OF INFORMATION FORM

ACKNOWLEDGEMENT OF HIPAA PRIVACY PRACTICES

I acknowledge that I received, reviewed, was offered, or am familiar with the HIPAA Notice of Privacy Practices of Barrington Orthopedic Specialists. (v. 8/2023) Initials: _____

DEMOGRAPHIC & MEDICAL HISTORY INFORMATION

I have reviewed the demographic and medical history information as it was entered into my electronic record. I verify that all the information is current and accurate to my knowledge. Initials: _____

EMERGENCY CONTACT NAME

Name: _____ Phone Number: _____

INFORMATION RELEASE

I authorize my private health information to be discussed with the following people, either over the phone or in the office, and/or grant permission for them to pick-up records or prescriptions on my behalf:

Name	Relationship
_____	_____
_____	_____
_____	_____

I authorize private health information to be left on a voicemail/answering machine at the following numbers:

Phone Number	Location (home/work/cell)
_____	_____
_____	_____

I authorize Barrington Orthopedic Specialists to email me private health information at the following email address:
Email Address: _____

I am aware Barrington Orthopedic Specialists may send me a secure text message including private health information.

I verify that all the demographic and medical history information I have reviewed is current and correct. I have received all information regarding Barrington Orthopedic Specialists policies and practices. (v.8/23)

Signature: _____ Date: _____

BARRINGTON
Orthopedic Specialists
Specializing in You

PATIENT FINANCIAL POLICY

As health care providers we are committed to providing our patients with the best medical care possible. As a business, we are committed to providing a streamlined fiscal process that allows our patients to clearly understand their financial responsibility. Our Business Office is available to assist you if you have any questions at the following number 847-285-4230.

Identification

Photo identification must be presented.

Due to frequent changes in insurance plans and the benefits offered under those plans, our staff is required to review and update your primary and secondary insurance information on a monthly basis. **Failure to provide current and up to date insurance information or failure to respond to insurance requests in a timely manner will result in the patient being responsible for services rendered.**

Health Insurance

Co-Payments

- Insurance companies require that co-payments are collected prior to services rendered.
- If you are unable to pay your co-pay at the time of service your appointment will be rescheduled.
- Co-pay's may vary dependent upon services provided.

Co-Insurance

- Coinsurance and deductible amounts are patient responsibility.

Deductibles

- Coinsurance and deductible amounts are patient responsibility.
- $200 deposit will be collected at each appointment for new patient/ new condition until the deductible has been satisfied.
- $100 deposit will be collected at each appointment for all follow-up appointments until the deductible has been satisfied.
- If a medical procedure is required, you will need to pay a deposit for any outstanding deductible and/or co-insurance.

Managing your Insurance

- Patients are responsible for knowing the rules of their insurance policy (i.e. precertification, Durable Medical equipment and supplies, injections, and Rehabilitation) this may not be an all-inclusive list. In the event of payment denial due to your noncompliance the balance will be your responsibility.
- Barrington Orthopedic Specialists requires a $200 deposit for all out of network plans at each office visit.
- We recommend contacting your insurance company prior to any service so you may understand your allowable benefits.
- You are responsible for managing your insurance.
- As insurance companies use disclaimers when providing benefits to us, Barrington Orthopedic Specialists is not responsible for any inaccurate or undisclosed information from your insurance company. This includes **Pre- certification** of services required.

BARRINGTON
Orthopedic Specialists
Specializing in You

Referrals

- If your insurance company requires a referral and/or authorization, you are responsible to have your Primary Care Physician send a referral to our office **prior** to your appointment. If you do not have a current valid referral, you have the option of rescheduling your appointment or paying for the visit at the time of service. Referrals cannot be backdated for services already rendered. Patients will be responsible for any denials related to no authorization or referrals on file.

Medicare

- **Patients are responsible for non-covered Medicare services.** Certain services may require the patient to sign an Advanced Beneficiary Notice.

Medicaid/All Kids

- Barrington Orthopedic Specialists will only accept Medicaid as a primary insurance when it is related to outside contractual obligations.

Self-Pay

- A deposit of $300.00 is required for initial services, $200.00 deposit and balance due is required at all follow up visits.
- Rehab patients are required to pay for services rendered at the time of service.
- Ancillary Services may require payment at the time services are rendered.

Credit Card on File Requirement

- To help manage patient balances as well as to make payment more convenient for you, Barrington Orthopedic Specialists requires each of our patients to maintain a securely stored credit, debit or HSA/FSA card with our office.
    - This card will be used to pay future balances or copays.
    - Your card will be encrypted and not stored onsite.
    - The card agreement will be valid for 1 year.
    - An e-mail will be sent to you 5 days before your card is charged after insurance process the claim.
    - You may cancel your agreement at any time.
    - To dispute any charges, contact our customer service team at 847-285-4230.

BARRINGTON
Orthopedic Specialists
Specializing in You

Statements/Payments

Statements

- Balances are due upon receipt of your statement.
- Any account which is 90 days delinquent will be referred to our collection agency and collection methods legally available to us will be instituted. The patient or the patient's guarantor is financially responsible for all costs associated with placement to an outside agency.

Collection Balances

- In addition to the principle amount owed any balance that is turned over to our collection agency will be responsible for an additional 25% which may include, but is not limited to, filing fees, court costs, collection agency fees and/or attorney fees.

Due to contractual obligations with insurance companies Barrington Orthopedic Specialists does not negotiate discounts on Deductible, Coinsurance, or Co-payments

Payment Methods

- We accept all major credit cards, debit cards, checks, money orders, cash, Electronic check transactions, Care Credit, HSA, and FSA Cards.

Returned Check Fees- a fee of $50 will be charged for all returned checks

Medical Products and Supplies

- Medical products and supplies dispensed to patients are non-refundable and non-returnable.

Workers' Compensation

- Patients shall be financially responsible for medical services related to Workers' Compensation.
- Patients shall supply Workers' Compensation contact information prior to services being rendered.
- Barrington Orthopedic Specialists will require your health insurance information in the event your Workers' Compensation claim is denied.

Motor Vehicle/Third Party Liability

- Patients shall be financially responsible for medical services related to motor vehicle accidents and third party liability cases

BARRINGTON
Orthopedic Specialists
Specializing in You

- Before accepting your accident case you will be required to sign the lien disclosure document which outlines how billing will be handled.
- Patients shall supply auto insurance, third party, health insurance, and/or attorney information as request by Barrington Orthopedic Specialists.
- Barrington Orthopedic Specialists reserves the right bill your health insurance for any third party liability case

Lien Policy

Barrington Orthopedic Specialists will assess your account to determine who to bill. We will initially bill to your automobile insurance or Medpay. If the 3rd party is pursued then the recovery from the third party will be the primary payer and final reimbursement is governed by the Illinois Health Care Services Lien Act, 770 ILCS 23, et. seq (the "Lien Act"). We will not bill the health insurance and will refund any money received by them. We will recover the full amount of it's customary and reasonable charges from the third party, pursuant to the Illinois Lien Act.

If we bill the health insurance, then all co-pays, deductible amounts, and co-insurance are the responsibility of the guarantor pursuant to the applicable health plan. The Physicians Lien will only be released after the balance is paid in full.

Cancellation/ No-show Policy

- If you need to cancel your appointment, please call us at least 24 hours in advance. We appreciate as much notice as possible.
    - Patients with three cancellations and/or no-shows cannot schedule future appointments unless deemed medically necessary.
    - Patients are subject to a cancellation and/or no-show charge.

I hereby assign, to Barrington Orthopedic Specialists, payment of medial reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine my benefits. This authorization shall remain valid until written notice is given by me revoking the said authorization. **I understand I am financially responsible for ALL charges whether or not they are covered by my Health Insurance, Medicare, Medicaid/All Kids as well as any deductible, co-payments or co-insurance.**

Printed Name: _____

Signature: _____

Date: _____

PSR Initials: _____