



Chicago Orthopaedics

& SPORTS MEDICINE, S.C.

| | YES | NO | | YES | NO |
|-----------------------------------|--------------------------|--------------------------|-----------------------------------|--------------------------|--------------------------|
| <u>CONSTITUTIONAL SYSTEMS</u> | | | <u>MUSCULOSKELETAL</u> | | |
| Good general health lately | <input type="checkbox"/> | <input type="checkbox"/> | Joint stiffness, swelling or pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Recent weight change | <input type="checkbox"/> | <input type="checkbox"/> | Weakness of muscles or joints | <input type="checkbox"/> | <input type="checkbox"/> |
| Fever | <input type="checkbox"/> | <input type="checkbox"/> | Muscle pain or cramps | <input type="checkbox"/> | <input type="checkbox"/> |
| Tired | <input type="checkbox"/> | <input type="checkbox"/> | Back pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Headaches | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| <u>CARDIOVASCULAR</u> | | | <u>INTEGUMENTARY (SKIN)</u> | | |
| Heart trouble | <input type="checkbox"/> | <input type="checkbox"/> | Rash or itching | <input type="checkbox"/> | <input type="checkbox"/> |
| Chest pain or angina | <input type="checkbox"/> | <input type="checkbox"/> | Change in skin color | <input type="checkbox"/> | <input type="checkbox"/> |
| Palpitation | <input type="checkbox"/> | <input type="checkbox"/> | Varicose veins | <input type="checkbox"/> | <input type="checkbox"/> |
| Shortness of breath | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Swelling of feet, ankles or hands | <input type="checkbox"/> | <input type="checkbox"/> | <u>ENDOCRINE</u> | | |
| Muscle discomfort while walking | <input type="checkbox"/> | <input type="checkbox"/> | Glandular or hormone problem | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Thyroid disease | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Excessive thirst or urination | <input type="checkbox"/> | <input type="checkbox"/> |
| <u>NEUROLOGICAL</u> | | | Heat or cold intolerance | <input type="checkbox"/> | <input type="checkbox"/> |
| Light headed or dizzy | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Numbness or tingling sensations | <input type="checkbox"/> | <input type="checkbox"/> | <u>HEMATOLOGIC/LYMPHATIC</u> | | |
| Paralysis | <input type="checkbox"/> | <input type="checkbox"/> | Slow to heal after cuts | <input type="checkbox"/> | <input type="checkbox"/> |
| Head injury | <input type="checkbox"/> | <input type="checkbox"/> | Anemia | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | | |
| <u>GASTROINTESTINAL</u> | | | <u>RESPIRATORY</u> | | |
| Loss of appetite | <input type="checkbox"/> | <input type="checkbox"/> | Chronic or frequent coughs | <input type="checkbox"/> | <input type="checkbox"/> |
| Nausea or vomiting | <input type="checkbox"/> | <input type="checkbox"/> | Spitting up blood | <input type="checkbox"/> | <input type="checkbox"/> |
| Rectal bleeding or blood in stool | <input type="checkbox"/> | <input type="checkbox"/> | Asthma or wheezing | <input type="checkbox"/> | <input type="checkbox"/> |
| Abdominal pain or heartburn | <input type="checkbox"/> | <input type="checkbox"/> | | | |

Physician signature _____

*Chicago Orthopaedics and Sports Medicine
3000 North Halsted, Suite 525
Chicago, IL 60657*

CONSENT FOR TREATMENT

I acknowledge and understand that in presenting myself for medical care and treatment at Chicago Orthopaedics and Sports Medicine (COSM) that I authorize and consent to the administration and performance of any tests, examinations, treatments, or physical therapy, which may be ordered by the physician and/or designated assistant and carried out by COSM staff. I understand that this consent will remain in effect until I choose to revoke it in writing.

Minors must be accompanied by a parent or legal guardian in order to obtain medical services.

Patient signature _____ *Date* _____

Chicago Orthopaedics and Sports Medicine Financial Policy

ASSIGNMENT OF BENEFITS & AUTHORIZATION TO RELEASE INFORMATION

In consideration of any services rendered to me by Chicago Orthopaedics and Sports Medicine, I hereby authorize and assign any and all reimbursement pertaining to said services to be made on my behalf and paid directly to COSM. If my insurance benefits are provided to me through Medicare, I hereby authorize and assign any and all reimbursement made under my Medicare plan which pertain to any services provided to me by COSM to be paid directly to Chicago Orthopaedics and Sports Medicine on my behalf.

I authorize Chicago Orthopaedics and Sports Medicine to release and disclose any medical information about me that pertains to any and all medical care, tests, treatment, or advice that was rendered to me by physicians and/or staff at Chicago Orthopaedics and Sports Medicine to insurance companies, third party payers, authorized agents, claims review organizations, and/or Medicare in order to process a claim and/or payment on my behalf.

PAYMENT AGREEMENT

I understand that providing I present a valid and current insurance card prior to services being rendered, COSM will file a claim to my insurance company but that does not guarantee payment which ultimately I am responsible for. I hereby accept and assume financial responsibility for any covered or non-covered services not paid by my insurance company. I am responsible for providing any referral required by my insurance company prior to services rendered to me and will be responsible for any services that are unpaid as a result of not providing COSM with a valid referral. If there are any questions, problems, or delays regarding my coverage &/or benefits, I understand that it is my responsibility to resolve these issues with my insurance carrier and the COSM billing office.

Deductibles, copayments, and payment for non-covered services will be due at time of service.

Self-pay patients will be expected to pay for their services in full at the time of the visit unless a prior alternate financial arrangement has been made with a COSM authority.

Patient signature _____ *Date* _____

****For patients provided with Durable Medical Equipment a copy of the supplier standards is available on request****

****For your information, the health care professionals in this practice are financially integrated. If you are referred to a healthcare professional in this practice for physical therapy services, please note that you may request & receive a referral for these services outside or independent of this practice.**