WELCOME TO CENTRAL ILLINOIS NEURO HEALTH SCIENCES

To better serve your healthcare needs, we need some information about your medical history. Please answer the following questions as completely as possible.
Thank You.

PERSONAL INFORMATION:

Name _____ Date of Birth_____ Age_____ Sex___ Marital Status ____

Address _____ City_____ State_____ Zip _____

Home Ph._____ Work Ph._____ Cell Ph. _____

May we contact you at work?_____ May we leave a message at home, work and/or cell? _____

Social Security Number _____ EMail Address: _____

Race (Check One): Caucasian _____ Black _____ Hispanic _____ Asian _____ Native American _____ Pacific Islander _____
Native Alaskan _____ Native Hawaiian _____ Other _____ Prefer Not to Indicate _____
Ethnicity (Check One): Latino _____ Non-Latino _____ Prefer Not to Indicate _____

Primary Physician _____ Referring Physician _____

Occupation_____ Employer _____

Would you describe your work as: (check one) Light_____ Medium_____ Heavy Labor _____

STATED HEIGHT: _____ STATED WEIGHT: _____

CHIEF COMPLAINT/Symptoms for which you are here today (Please describe exactly what you are feeling and where)

_____

_____

When did symptoms begin? _____

What makes them better? _____

What makes them worse? _____

Were your symptoms the result of an injury? YES_____ NO_____ (If yes, please describe) _____

_____

_____

How have you treated your symptoms? _____

Have you had any of the following tests in the past 6 months? (Please specify date and where tests were done on line below)

CT Scan____ MRI____ Myelogram____ X-rays____ EMG ____ Bone Density____

_____

Are you claustrophobic? Yes _____ No _____

Do you take a calcium or osteoporotic supplement? Yes ____ No ____ If yes, which? _____

MEDICAL HISTORY:

☐ I have NO allergies ☐ I have the following allergies:

Name:_____ Reaction_____ Name:_____ Reaction_____
Name:_____ Reaction_____ Name:_____ Reaction_____
Name:_____ Reaction_____ Name:_____ Reaction_____
Seafood:_____ Medical Dyes_____ Tape_____ Other: _____

PATIENT NAME / DATE OF BIRTH: _____

Current Medications: (Include any vitamins, over-the-counter meds, herbal meds, as well as prescribed meds.) If None, write "None" in the first entry.

Name_____ Dose_____ When Taken _____
Name_____ Dose_____ When Taken _____
Name_____ Dose_____ When Taken _____
Name_____ Dose_____ When Taken _____
Name_____ Dose_____ When Taken _____
Name_____ Dose_____ When Taken _____
Name_____ Dose_____ When Taken _____
Name_____ Dose_____ When Taken _____
Name_____ Dose_____ When Taken _____
Name_____ Dose_____ When Taken _____
Name_____ Dose_____ When Taken _____
Name_____ Dose_____ When Taken _____

Previous Surgeries: _____

_____

Previous Hospitalizations: _____

_____

Have you had a flu vaccine, if so, when? _____ Have you had a pneumonia vaccine, if so, when? _____

PATIENT SOCIAL HISTORY

Marital Status: Married ☐ Single ☐ Widowed ☐ Divorced ☐

Emergency Contact: _____

Relationship: _____ Phone: _____

Have you ever smoked? Yes ____ No _____ If Yes, how long? _____ Number of packs/day? _____

Do you smoke now? Yes ____ No _____ If Yes, number of packs/day? _____

Do you drink alcohol? Yes ____ No _____ If Yes, how much per week? _____

Daily caffeine intake: _____

Do you take any street drugs? Yes ____ No _____ If Yes, list them: _____

Do you routinely use prescription narcotics? Yes ____ No ____ If YES, specify type/amount used in the last 6 months:

_____

_____

_____

PATIENT NAME / DATE OF BIRTH: _____

PATIENT/FAMILY REVIEW OF SYSTEMS - PLEASE FILL OUT COMPLETELY

	Self		Family Member	
	YES	NO	YES	NO
Ears, Nose, Throat, Mouth				
Swallowing Difficulty	☐	☐	☐	☐
Eyes				
Glaucoma	☐	☐	☐	☐
Cataracts	☐	☐	☐	☐
Throat				
Thyroid Disease	☐	☐	☐	☐
Respiratory				
Pneumonia	☐	☐	☐	☐
Bronchitis	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Emphysema	☐	☐	☐	☐
Cardiovascular				
Anemia	☐	☐	☐	☐
Bleeding Disorders	☐	☐	☐	☐
Leukemia	☐	☐	☐	☐
Circulatory Problem	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐
Heart Murmur	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
Extremities				
Gout	☐	☐	☐	☐
Psychiatric/ Psychological Disorder	☐	☐	☐	☐

	Self		Family Member	
	YES	NO	YES	NO
Gastrointestinal				
Diabetes	☐	☐	☐	☐
Stomach Disorder	☐	☐	☐	☐
Bowel Disorder	☐	☐	☐	☐
Hepatitis	☐	☐	☐	☐
Genitourinary				
Kidney Disorder	☐	☐	☐	☐
Breast Disorder	☐	☐	☐	☐
Musculoskeletal				
Fibromyalgia	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐
Rheumatoid Arthritis	☐	☐	☐	☐
Neurological				
Multiple Sclerosis	☐	☐	☐	☐
Muscular Dystrophy	☐	☐	☐	☐
Head Injury	☐	☐	☐	☐
Stroke/TIA	☐	☐	☐	☐
Epilepsy/Seizures	☐	☐	☐	☐
Spina Bifida	☐	☐	☐	☐
Migraines	☐	☐	☐	☐
Other				
Skin Disorder	☐	☐	☐	☐
Cancer	☐	☐	☐	☐

If Cancer, specify site: _____

Please specify any other condition: _____

By signing, I verify this information to be accurate and true. _____

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

CENTRAL ILLINOIS NEURO HEALTH SCIENCES

INSURANCE INFORMATION

Patient Name and Date of Birth: _____

Please provide us with your Health Insurance Information

PRIMARY INSURANCE:

Company Name:_____Phone: _____
Address: _____
City/State/Zip:_____
Policy#: _____Group #:_____
Policy Holder Name and Date of Birth: _____

SECONDARY INSURANCE:

Company Name:_____Phone: _____
Address: _____
City/State/Zip:_____
Policy#: _____Group #:_____
Policy Holder Name and Date of Birth: _____

WORKER'S COMPENSATION CLAIM INFORMATION

Company Name:_____
Case Worker or Contact Person:_____
Billing Address: _____
City/State/Zip:_____
Phone: _____

Thank you for completing this information request. It will help us to better manage your health care concerns.

I agree that the above information has been answered accurately and is true.

_____

Patient Signature Date

CENTRAL ILLINOIS NEURO HEALTH SCIENCES

AUTHORIZATIONS / ASSIGNMENTS

Patient Name and Date of Birth: _____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the release of any medical information pertinent to my medical care to Central Illinois Neuro Health Sciences.

Non-Medicare Patients: I hereby authorize the release of all medical information necessary to process my claims and information that is pertinent to my medical care, including medical records, diagnostic tests and results.

Medicare Patients: I hereby authorize any holder of medical information about me to be released to Health Care Financing Administration and its agents for any information needed to determine benefits payable for related services.

I certify that the information given by me in applying for Insurance benefits is correct.

Patient Signature:_____Date:_____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of all medical and/or surgical benefits, including major medical benefits to which I am entitled, to Central Illinois Neuro Health Sciences.

I **further understand** that it is my responsibility to pay the deductible, co-insurance, and any other balances not paid by my Insurance.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Patient Signature:_____Date:_____

PATIENT CONSENT FOR RESEARCH

Central Illinois Neuro Sciences is proud to be involved in continuing medical education and professional teaching programs. We are actively engaged in the training of Neurosurgery residents, medical students, nurses and operating room technicians and are committed to furthering the education of physicians already in practice.

By signing this Consent Form, you are authorizing CINHS to utilize your health information for presentation for scientific or educational purposes. However, your identity will not be disclosed in publication or in any presentations.

Patient Signature:_____Date:_____

CENTRAL ILLINOIS NEURO HEALTH SCIENCES

PRIVACY NOTICE

Patient Name and Date of Birth: _____

Privacy Act Notice

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare Providers who may be involved in that treatment directly and indirectly.

- Obtain payment from third-party payers.

- Conduct normal healthcare operations such as quality assessments and physician Certificates.

I have been informed, either by you or by your Notice of Privacy Practices, containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, and/or health care programs. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

I agree that I have read or received a copy of the Privacy Notice Act.

Patient Signature:_____Date:_____

1015 S. Mercer Ave.
Bloomington, IL 61701-7107
(309) 662-7500 (309) 662-7333 Fax

CENTRAL ILLINOIS NEUROHEALTH SCIENCES
FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to providing you with the finest health care available. All patients must complete and sign all check-in forms before seeing the doctor. You are required to bring your insurance card(s) and picture ID to every visit. Be sure to inform the receptionist of any changes in address, phone numbers, or insurance coverage.

OFFICE VISITS: Payment in full for all office visits is expected on the day of your appointment unless you have insurance that will be filed for your visit. Your copay will be collected before you are seen by the physician. We accept cash, check or credit cards (VISA, MasterCard, Discover and American Express). **Failure to pay your copay will result in your appointment being rescheduled.**

Authorization for office visits: If your insurance requires authorization to see a specialist, or if you are part of an exclusive network, it is your responsibility to make sure that you are able to see our doctors. If you have concerns about whether or not your visit needs authorization, please contact your referring provider or insurance carrier. If you are referred to Diagnostic Neuro Technology for additional services, please be aware that DNT is a separate company and may have different network participation. You are encouraged to call your insurance before services are rendered if you are uncertain about your network. **Any balances incurred because of lack of authorization or networks will be your responsibility to pay.**

Workers Compensation Cases: If you are visiting as a patient under Worker's Compensation, we must have a documented referral at the time of your visit and have your adjuster call and give information about your case prior to your appointment, **Failure to provide this information will result in your visit being rescheduled.** If the status of your worker's compensation case changes, or if you file a claim after services are rendered, it is your responsibility to inform us of these changes. Failure to do so may result in higher out-of-pocket balances at the time your case settles, as we will be unable to handle the billing of your claim appropriately.

Third Party Payors: If you are being represented by an attorney as a result of an accident or injury, including motor vehicle-related injury, we will submit claims to your group health plan, and you will be responsible for your bill at the time services are rendered. No arrangements will be made based on prospective third-party payors, nor will we submit claims to your motor vehicle carrier. You may contact your adjuster to discuss how you can be reimbursed.

Self Pay: If you are a self-pay patient, you will be required to pay the full self pay fee before being seen by the physician. **Your appointment will be rescheduled if you are unable to pay fpr your visit at the time of service.**

Surgical Procedures: If after consultation with the doctor your condition requires surgery, the procedure will be scheduled and our office will contact your insurance company to obtain preauthorization. However, verification of benefits is not a guarantee of payment from your insurance company. It is YOUR responsibility to contact your insurance company if you have any concerns.

Billing Procedures: As a courtesy, our billing service will submit your insurance claim on your behalf. Therefore, it is essential that we have complete and accurate information about your insurance carrier. Please remember that your insurance policy is an agreement between you and the insurance company. **Any charges not covered by your policy are your responsibility.** You may appeal with your insurance company if you disagree with their decision.

Collection Process: Just as we make every effort to accommodate you when you are in need of medical care, we expect that you will make every effort to pay your bill promptly. You will receive a monthly statement from our Billing Service. They will be able to help you with any questions that you may have. Please understand that our services are separate from the hospital; therefore, you will receive a statement from us as well as the hospital.

Delinquent Accounts: If your account has no payment for sixty days and becomes delinquent, and you have not established or kept a payment plan with our Billing Service, your account may be turned over to a collection agency.

Forms and Medical Records: If you require our office to complete any forms for disability or work purposes, there will be a $20 charge for each form to be collected prior to the form being completed. Please allow fourteen business days for the completion. If you require a copy of your medical records, you must sign a Medical Records Release of Information form and a fee based on the number of pages will be calculated.

I have read the financial policy and agree to its terms.

_____
Print Name of Patient

_____ _____
Signature of Patient (or responsible party if minor) Date