ADVANCED MEDICAL & REHABILITATION LTD.

3200 W Higgins Rd.
Hoffman Estates, IL 60169
Phone: (224) 804-1844
Fax: (847) 557-1270

150 W. Half Day Rd. Suite 101
Buffalo Grove, IL 60089
Phone: (224) 804-1844
Fax: (847) 557-1270

Last Name: _____ Frist Name: _____

Home Phone: _____ Cell Phone: _____

Email: _____ DOB: _____ Sex: M / F

Home Address: _____

City: _____ State: _____ Zip Code_____

Contact in case of Emergency: Name: _____ P: _____

Primary Care Physician PCP: _____ P: _____

Whom may we thank for referring you to us? _____

Assignment of Insurance Benefits: I hereby authorize direct payments of medical benefits to Advanced Medical & Rehabilitation for services rendered in the office. I understand that I am financially responsible for any balance not covered by my insurance. I further understand that if I default, and outside collection efforts are requested, I will be responsible for all collection fees, court costs, attorney fees, as well as any interest allowed by law.

Patient Initials: _____

Authorization to Release Information: I hereby authorize to release any medical information pertaining to my treatment, and permit any insurer to inspect my medical records in connection with any charges arising from this treatment.

Patient Initials: _____

Cancellation Policy:

- Appointment cancellations made within less than 24 hours will result in a full appointment fee of $150.
- In the case of needing to reschedule, we ask that you notify us no less than 4 hours prior to your scheduled visit. Notices made less than 4 hours in advance will result in a fee of $75.
- No Show will result in a $150 fee.

These fees must be paid prior to your next appointment.

Patient Initials: _____

We keep medical records in our archive for a period of 3 years. To request a copy of your medical records: -Must be done in writing; - At least 7 days in advance; - Comptroller fee recommendations (Code of Civil Procedure 735 ILCS 5/8-2001(d)) will be applied.

Patient Initials: _____

I have carefully read all of the information above, and answered all of the questions. I certify that the information provided here is true and correct to the best of my knowledge. I will notify Advanced Medical & Rehabilitation of any changes in my status or above information.

Patient Signature: _____ **Date:** _____

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Patient Name: _____ DOB: _____

MEDICAL HISTORY

Past Medical history (major events and surgeries with dates, any head trauma with loss of consciousness and no medical treatment with date):

_____

Current medical history include chronic diseases and any conditions that you are being prescribed medications for treatment:

_____

Family Medical History- include mother, mother's parents, sisters, brothers, cousins, father, father's parents, sisters, brothers, cousins:

Cardiovascular: ☐ Diabetes: ☐

Cancer: _____ Arthritis/ Psoriasis: _____

Allergies: _____

Social History:

Smoking: _____ Alcohol: _____ Caffeine: _____

Medications:

_____

_____

_____

_____

_____

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.

MY PLEDGE REGARDING MEDICAL INFORMATION: I understand that medical information about you and your health is personal. I am committed to protecting medical information about you. It is my duty to safeguard your Protected Health Information (PHI). Your personal doctor or other community-based providers may have different policies or notices regarding their use and disclosure of your medical information or PHI created in their offices, clinics, or facilities.

This Notice will tell you about ways in which I may use and disclose medical information about you. I also describe your rights and certain obligations I have regarding the use and
disclosure of medical information. If I significantly change my privacy practices I will revise this Notice and make it available to you at your next appointment.

Contents of this Notice:

I. Introduction to Notice and PHI

This Notice will tell you how I handle information about you. It tells how I use this information here in this office, how I share it with other professionals and organizations, and how you can see it. I want you to know all of this so that you can make the best decisions for yourself and your family. I am also required to tell you about this because of the privacy regulations of a federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Each time you visit this practice or any doctor's office, hospital, clinic, or any other "healthcare provider," information is collected about you and your physical and mental health. It may be information from your past, present, or future health/conditions. It may also be information of the treatment or other services you received from your therapist or from others or about payment for healthcare. The information collected from you is called, in the law, Protected Health Information (PHI). This information goes into your medical or healthcare record or file. At this clinic, this PHI is likely to include these kinds of information:

I. Your History – as a child, in school, at work, marital, and other personal history.
II. Reasons you came for treatment (i.e., problems, complaints, symptoms, and/or goals).
III. Diagnoses – medical terms for your symptoms.
IV. A treatment plan for therapy.
V. Progress notes – written account of what occurs during our sessions.
VI. Records obtained from other providers.
VII. Educational or Psychological testing – results and interpretations.
VIII. Information about medications you took or are taking.
IX. Billing information.

This information is used to:
To plan your care and treatment.

To decide how well the treatments are working for you.

To discuss your treatment with other healthcare providers who are also treating you.

To show that you actually received the services for which you were billed.

Patient Name: _____DOB_____

Patient Signature: _____ Todays Date: _____

HIPAA NOTICE OF PRIVACY PRACTICES

Your right to privacy in this medical practice is paramount and we will never disclose any of your personal information without your express consent, unless required to do so by law.

This notice describes our office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected. Please read it carefully.

The Physician will acquire private information about their patients. This is confidential and will not be discussed outside the office, except that the Physician may discuss patients with other healthcare professionals in terms that do not allow identification of the individual.

Your protected health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment, or treatment.

Your health care records, as well as your billing records, may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for payment of services provided to you.

Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you. If you are not home to receive an appointment reminder or other related information, a message may be left on your answering machine or with a person in your household. You have a right to confidential communications and to request restrictions relative to such contacts, or contact by alternative means.

Additionally, we may be required to disclose your health information in the following circumstances: In the event of an emergency; if required by law; if there are substantial barriers to communicating with you, but in our professional judgement we believe that you intend for us to provide care; if ordered by the courts, government authorities, public health, law enforcement, coroners, or funeral directors; in the event of organ donations, research, military activity, or for national security.

Patients have the right to receive an accounting of any such disclosures made by our office.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

If you would like copies of records, you must submit a written request for copies of medical records at least 7 business days in advance. You will be charged in accordance with the state of Illinois allowable fee/rate for the copying and retrieval of medical records.

As per Illinois Administrative code: our office shall maintain a patient's record a minimum of six years following the last patient encounter with the following exceptions:

- Records of a minor child, including immunizations, shall be maintained until the child reaches the age of 18 or becomes emancipated, with a minimum time for record retention of six years from the last patient encounter regardless of the age of the child; or
- Records that have previously been transferred to another practitioner or health care provider or provided to the patient or his personal representative;
- Records that are required by contractual obligation or federal law may need to be maintained for a longer period of time.

By Signing, I acknowledge that I understand and agree to Advanced Medical & Rehabilitation Privacy Policy.

Patient Name: _____DOB_____

Patient Signature: _____ Todays Date: _____

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General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient Name: _____DOB_____

Patient Signature: _____ Todays Date: _____

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General Consent for Procedure

I (or my authorized representative, i.e., parent guardian), _____, consent to the medical procedures that may be performed by Tamara Gurevich MD and his/her staff, associates, or assistants to whom the physician(s) performing the procedure may assign designated responsibilities. I understand that these procedures are to treat not diagnose my symptoms.

The procedures will be explained to me in terms that I understand. The explanation included:

• The nature and extent of the procedure to be performed.

• The most frequently occurring risks of the procedure involved, and those risks which are unlikely to occur but which may involve serious consequences.

• General risks which may include pain, scarring, bleeding and infection.

• The benefits of the procedure.

• The estimated period of incapacity or convalescence, if any.

• The risks and benefits of any reasonable alternatives to this procedure including having no treatment at all.

I understand that I will be given the opportunity to ask any questions I have regarding the procedure and I have had those questions answered to my satisfaction.

I understand that I may consult or could have consulted with another physician about this procedure.

I understand that I have the right to refuse any medical treatment recommended at any time prior to its performance.

I authorize my physician to perform such additional procedures which in his/her judgment are incidentally necessary or appropriate to carry out my diagnosis/treatment.

If any unforeseen condition arises during this procedure which requires transportation to a hospital, additional procedures, operation or medication including anesthesia and blood transfusions, I further request and authorize my physician to do whatever he/she deems advisable on my behalf.

I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of this procedure.

I authorize the physician performing the procedure, or his/her staff, associate, or assistant to whom the physician may assign the responsibility, to use his or her discretion in disposing of or using any tissue or body parts that may be removed during the procedures.

I authorize that a representative or technician from a medical device company may be present at the procedure; medical photography may be utilized for medical, scientific, or educational purposes, provided my identity is not revealed in the photo or text.

I acknowledge that I have read (or had read to me) and fully understand the above information.

Furthermore, I certify that all my questions and concerns regarding the procedure, its attendant risks, benefits and alternatives have been explained to my satisfaction.

I hereby authorize my physician to perform the discussed procedures.

Patient Signature: _____ Date_____