

Advanced Medical & Rehabilitation, Ltd.

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150 W. Half Day Rd, Ste 205, Buffalo Grove, IL 60089
info@painmanagementchicago.com

Last Name: _____ First Name: _____

DOB: _____ Sex: M / F Phone: _____

Email: _____

Home Address:

City: _____ State: _____ Zip Code: _____

Emergency Contact: _____ Relation: _____

Phone: _____

Primary Care Physician (PCP): _____

Phone: _____

Referring Party: _____

Financial & Office Policies

- **Assignment of Insurance Benefits:** I hereby authorize direct payment of medical benefits to Advanced Medical & Rehabilitation, Ltd for services rendered. I understand that I am financially responsible for any balance not covered by my insurance. If I default and outside collection efforts are required, I will be responsible for all collection fees, court costs, attorney fees, and interest allowed by law. **Initials:** _____
- **Authorization to Release Information:** I authorize the release of medical information pertaining to my treatment to any insurer to inspect records in connection with charges arising from this treatment. **Initials:** _____
- **Cancellation Policy:** A **\$125 fee** will be charged for missed appointments unless cancelled at least **24 hours** prior to the scheduled time. This fee must be paid prior to the next appointment. **Initials:** _____
- **Medical Records:** Records are archived for 6 years. Requests for copies must be in writing, made 7 days in advance, and are subject to Comptroller fee recommendations (Code of Civil Procedure 735 ILCS 5/8-2001(d)). **Initials:** _____

Patient Signature: _____ Date: _____

MEDICAL HISTORY

Patient name: _____ DOB: _____

Past Medical History: (Include major events, surgeries with dates, and head trauma/loss of consciousness):

Current Medical History: (Include chronic diseases and conditions currently being treated):

Family Medical History: (Check all that apply to parents, siblings, or grandparents)

Cardiovascular Diabetes Cancer Arthritis/Psoriasis

Social History: Smoking: Yes / No Alcohol: Yes / No Caffeine: Yes/No ___ Cups a day

Allergies:

Current Medications:

Physician Notes:

HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed. Please review it carefully.

Our Pledge: We are committed to protecting your Protected Health Information (PHI). We use your PHI to plan your care, determine treatment efficacy, and coordinate with other healthcare providers. We may disclose PHI for:

- **Treatment:** Referral to other specialists or hospitals.
- **Payment:** Billing your insurance carrier, HMO, PPO, or employer.
- **Operations:** Appointment reminders (via phone/voicemail) or health-related alternatives.
- **Legal Requirements:** If required by law, court order, or public health emergencies.

Your Rights: You have the right to inspect your records and receive an accounting of disclosures. We maintain records for a minimum of six (6) years (or until age 18 for minors) per Illinois Administrative Code.

Acknowledgment: I have read and agree to the Advanced Medical & Rehabilitation, Ltd Privacy Policy.

Patient Signature: _____

Date: _____

GENERAL CONSENT FOR CARE AND TREATMENT

I voluntarily request that a physician and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist) perform reasonable and necessary medical examinations, testing, and treatment for my condition.

1. **Scope of Consent:** This consent is continuing in nature and remains effective until revoked in writing.
2. **Right to Information:** I have the right to discuss the treatment plan, risks, and benefits with my provider.
3. **Additional Procedures:** I understand that invasive or interventional procedures will require a separate, specific consent form.

Patient Signature: _____

Date: _____

GENERAL CONSENT FOR PROCEDURE

I, _____, authorize **Tamara Gurevich, MD**, and her designated staff to perform medical procedures to treat my symptoms.

- **Understanding:** The nature, risks (pain, scarring, bleeding, infection), and benefits of the procedure and its alternatives have been explained to me.
- **Right to Refuse:** I may refuse treatment at any time prior to its performance.
- **Emergency Authorization:** If an unforeseen condition arises requiring transport to a hospital or emergency medication, I authorize my physician to act on my behalf.
- **Results:** I acknowledge that medicine is not an exact science and no guarantees have been made regarding results.
- **Disposal & Photography:** I authorize the disposal of any removed tissue and the use of de-identified medical photography for scientific or educational purposes.

Patient Signature: _____

Date: _____

Informed Consent for Telehealth Consultations

To better serve the needs of the community, healthcare services are now available via interactive video communications and/or the electronic transmission of information. This process is referred to as “**telemedicine**” or “**telehealth**.” This technology assists in the evaluation, diagnosis, management, and treatment of various healthcare problems from a distant location. Because this differs from a traditional in-person consultation, it is important that you understand and agree to the following statements:

I. Nature of Telehealth

1. **Location of Provider:** The consulting healthcare provider or specialist will be at a different location from me. A physician or other healthcare provider (“presenting practitioner”) may be present with me in the room to assist with the consultation.
2. **Electronic Transmission:** The presenting practitioner may transmit or share electronically details of my medical history, examinations, X-rays, tests, photographs, or other images with the specialist at the distant location.
3. **Personnel:** I will be informed if any personnel other than the presenting practitioner and the consultant are present. I must give verbal permission before any additional personnel enter the consultation.
4. **Medical Records:** The presenting practitioner will maintain a record of the telehealth consultation within my permanent medical record.

II. Patient Rights and Responsibilities

5. **Right to Withdraw:** I understand that I have the option to refuse or withdraw from telehealth services at any time. This will not affect my right to future care or treatment, nor will it result in the loss of any program benefits to which I am entitled.
6. **Availability:** I agree to be available **1.5 to 2 hours** from my scheduled appointment time in the event of unexpected clinical delays.
7. **Follow-up Care:** I understand that I may be released before all medical problems are known or treated. It is my responsibility to make arrangements for necessary follow-up care.

III. Authorization and Consent

8. **Release of Information:** I authorize **Advanced Medical & Rehabilitation Ltd.** and its physicians to furnish medical information from my records to referring physicians, insurance companies, or third-party payers for the purpose of payment. I further authorize the release of information to any healthcare facility to which my care may be transferred.
9. **Voluntary Consent:** I voluntarily consent to healthcare services provided by my doctor(s) or their designee, including diagnostic tests, examinations, and treatments deemed necessary for my condition.

IV. Financial Agreement & Assignment of Benefits

- **Assignment of Benefits:** I authorize payment of all medical benefits (including Medicare, Medicaid, HMO/PPO, and Workers' Compensation) directly to **Advanced Medical & Rehabilitation Ltd.** * **Financial Responsibility:** I agree to pay all charges not covered by insurance, including deductibles, co-payments, or charges resulting from a failure to obtain pre-authorization.
- **Collections:** Should my account be referred for collection, I agree to pay reasonable attorney fees and collection expenses.

Patient name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____