Chicago Primary Care Sports Medicine
111 N. Wabash Ave. Suite 1919
Chicago, IL. 60602
312-616-7778 Fax: 312-276-4304

Patient Information/Informacion Del Paciente

Referred By: _____

Employer (Patrón): _____ Date (Fecha): _____ SSN: _____

First Name (Nombre): _____ Middle Initial (Inicial): _____ Last Name (Apellido): _____

If this is your first visit, please fill the blanks included in this box. (Si esta es su primera visita, por favor llene los espacios incluidos en este recuadro)

Address (Dirección): _____

City (Ciudad): _____ State (Estado): _____ Zip (C. Postal): _____

Home Phone (No. Telefono en casa): _____ Work Phone (No. Telefono en el trabajo): _____

Birthdate (Fecha de Nacimiento): _____ Sex (Sexo): _____ Marital Status (Estado Civil): _____

Date of Injury (Fecha de lesion): _____ Time (Hora): _____ Last day worked (Ultimo día que trabajo): _____

Occupation (Ocupación): _____

Address where injury occurred (Lugar donde ocurrió la lesion): _____

Was your problem caused by something that happened at work? (¿Su problema fue causada por algo sucedido en su trabajo?) _____

Injury was reported to (La lesion fue reportada a): _____ Date (Fecha): _____ Time (Hora): _____

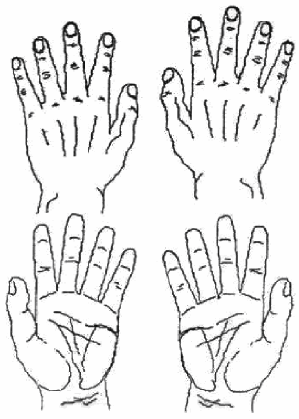
If this is your first visit, describe how your present injury/illness occurred. (Si esta es su primera visita, describa cómo ocurrió su actual lesion o enfermedad). If this is a follow up visit, indicate any improvement or change in your condition. (Si esta no es su primera visita, desriba cualquier mejoria o cambio en su condición).

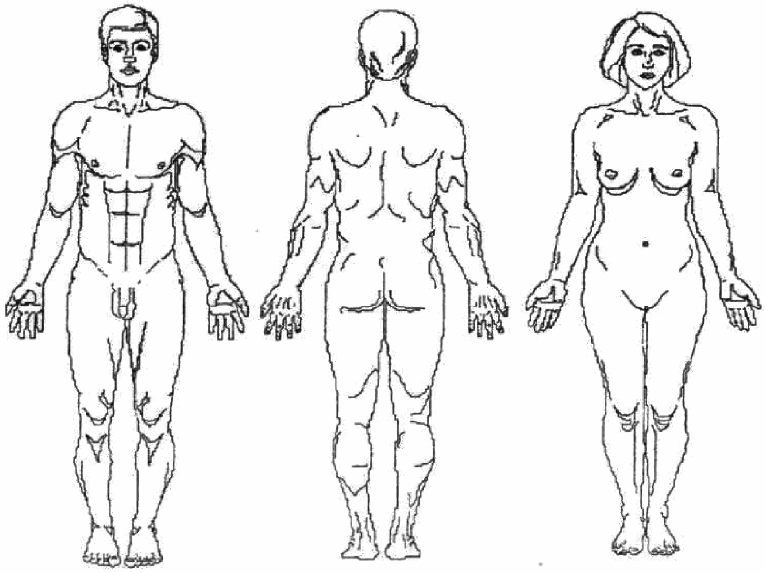
Please complete the following diagram (Por favor marque el diagram a continuación)
If you feel any of the symptoms below, mark the areas of the body where you feel them on the figures below and indicate the type of symptom. (Si siente alguno de los síntomas listados a continuación, marquee la zona del cuerpo en donde los siente en las figures e indique el tipo de síntoma.)

Symptoms (Síntomas)

A. Pain (Dolor)
B. Numbness (Adormecimiento)
C. Burning (Quemazón)
D. Pins/Needles (Pinchazos)

Rate the intensity of your pain: NO PAIN MOST PAIN
(Indique la intensidad de su dolor): SIN DOLOR DOLOR INTENSO
0 1 2 3 4 5 6 7 8 9 10





Patient Signature (Firma del Paciente) _____ **Date(Fecha)** _____

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HEALTH HISTORY / HISTORIA MEDICA

Confidential / Confidencial

To better assess your health condition and its impact in the resolution of your injury or illness, please provide the following information:

PLEASE ANSWER ALL QUESTIONS				POR FAVOR, CONTESTE TODAS LAS PREGUNTAS			
Yes/Si	No	PAST MEDICAL HISTORY / ANTECEDENTES MEDICOS		Yes/Si	No	PAST MEDICAL HISTORY / ANTECEDENTES MEDICOS	
		1. Allergies or hives	Alérgias o urticaria			42. Chronic / Recurrent Cough / Cold	Resfriado / tos crónica o recurrente
		2. Medications	Medicinas			43. Asthma / Wheezing	Asma o pitos (sibilancias) en el pecho
		3. Major illnesses or injuries	Enfermedades/lesiones importantes			44. Emphysema or chronic bronchitis	Enfisema o bronquitis crónica
		4. Hospitalizations or surgeries	Hospitalizaciones o cirugías			45. Pneumonia	Pneumonia o pulmonia
		5. Motor vehicle accidents	Accidentes de tránsito			46. Tuberculosis	Tuberculosis
		6. Blood transfusions	Tranfusiones de sangre			47. Coughing of Blood	Tos con sangre
		7. Worked in a harzardous environment	Trabajo en ambientes peligrosos			GASTROINTESTINAL TRACT	
		8. Work-related injuries/illnesses	Accidentes/enfermedades en el trabajo			48. Frequent indigestion or reflux	Indigestión o reflujo frecuentes
		9. Permanent disabilities	Incapacidad permanente			49. Nausea or vomiting	Náusea o vómitos
Yes/Si	No	FAMILY HISTORY / ANTECEDENTES FAMILIARES				50. Vomiting of Blood	Vómitos con sangre
		10. Blood diseases in relatives	Familiares con enfermedades de la sangre			51. Abdominal Pain	Dolor abdominal
		11. Cancer or leukemia in relatives	Familiares con cáncer or leucemia			52. Liver Disease	Enfermedades del hígado
		12. Diabetes in relatives	Familiares con diabetes			53. Change in Bowel Habits	Cambios en hábitos intestinales
		13. Heart Disease	Familiares con enfermedades del corazón			54. Frequent Constipation / Diarrhea	Constipación o diarea frecuentes
		14. High Blood Pressure	Familiares con presión alta			55. Blood in stools / Black stools	Heces negras o con sangre
		15. Strokes in relatives	amiliares con trombosis / ataques cerebrales			56. Hemorrhoids / Rectal Disease	Hemorroides o enfermedades del recto
		16. Mental illnesses in relatives	Familiares con enfermedades mentales			GENITOURINARY TRACT	
Yes/Si	No	SOCIAL HISTORY / ANTECEDENTES SOCIALES				57. Painful or difficult urination	Dificultad o dolor al orinar
		17. Tobacco use. How much? ____ week	Uso de tabaco. Cuanto? ____ semana			58. Blood in urine	Sangre en la orina
		18. Alcohol use. How much? ____ week	Uso de alcohol. Cuanto? ____ semana			59. Kidney infection / stones	Infecciones o cálculos del riñón
Yes/Si	No	REVIEW OF SYSTEMS / REVISION DE SISTEMAS				60. Venereal Disease	Enfermedades venéreas
HAVE YOU HAD OR DO YOU COMMONLY HAVE:		TIENE USTED NORMALMENTE O HA TENIDO:				MUSCULOSKELETAL	
		CONSTITUTIONAL				61. Joint pain or disease	Enfermedades o dolor en las articulaciones
		19. Recent gain or loss of weight	Ganancia o perdida de peso reciente			62. Neck or back injury	Lesiones del cuello o de la espalda
		20. Weakness, fatigue, or appetite loss	Debilidad, fatiga o perdida de apetito			63. Foot Problems	Problemas en los pies
		21. Fever	Fiebre			ENDOCRINE SYSTEM	
		SIGN				64. Epilepsy, Convulsions	Epilepsia, convulsiones, ataques
		22. Skin diseases or problems	Enfermedades en la piel			65. Dizziness	Mareos o vèrtigo
		23. Discoloration, pigmentation changes	Cambios de color en la piel			66. Muscle weakness or paralysis	Parálisis o debilidad muscular
		24. Cancer/Tumors or cysts	Cáncer, tumores o quistes			67. Numbness in arms or legs	Adormecimiento de manos o pies
		HEAD				PSYCHIATRIC PROBLEMS	
		25. Frequent or severe headaches	Dolores de cabeza frecuentes o severos			68. Depression	Depresión
		EYES / VISION				69. Nervousness	Nerviosismo
		26. Eye injury, infection or pain	Lesiones, infección o dolor en los ojos			70. Mood swings	Cambios del humor o del carácter
		27. Blurred, double or decreased vision	Visión borrosa, doble, o disminuida			71. Sleep disturbances	Trastromos del sueño
		28. Eye itching, burning or tearing	Lagrimeo, picazón o quemazón en ojos			72. Alcoholism	Alcoholismo
		29. Light sensitivity	Sensibilidad a la luz			73. Drug abuse treatment / rehabilitation	Rehabilitación por adicción a drogas
		EARS, NOSE, THROAT, MOUTH				ENDOCRINE SYSTEM	
		30. Loss or decreased hearing	Pérdida o disminución			74. Increased appetite	Apetito exagerado
		31. Ear pain, infection, discharge	Dolor , infección o secresión en oídos			75. Increased thirst	Sed exagerada
		32. Nose / Sinus problems	Problemas en la nariz o en senos nasales			76. Increased urination	Aumento en la frecuencia o cantidad de orina
		33. Dental / Gum Disease	Enfermedades dentales o de las encías			77. Diabetes / High Blood Sugar	Diabetes / Azúcar en la sangre
		34. Recurrent throat problems	Problemas de garganta recurrentes			78. Hair loss	Pérdida del cabello
		35. Voice Change / Hoarseness	Ronquera o cambios en la voz			BLOOD DISORDERS	
		CARDIOVASCULAR SYSTEM				79. Bleeding gums	Sangramiento por las encías
		36. Shortness of Breath	Dificultad para respirar			80. Bruising	Moretones o cardenales
		37. Chest Pain or Pressure	Opresión o dolor en el pecho			81. Spontaneous nose bleeding	Sangramiento espontáneo por la nariz
		38. Palpitation / Pounding Heart	Palpitaciones o saltos del corazón			82. Easy bleeding or hard to stop	Sangramiento fácil o difícil de detener
		39. High Blood Pressure	Presión sanguinea elevada			FOR WOMEN ONLY	
		40. Swelling Feet / Ankles	Hinchazón de pies o tobillos			83. Pregnant?	Embarazada?
		41. Varicose Veins	Venas varicosas			84. Date last menstrual period? _____	Fecha última de menstruación?
						85. Irregular Menstruation?	¿Menstruación o períodos irregulares?
						86. Painful Menstruation	¿Menstruación o períodos dolorosos?

PLEASE WRITE THE NUMBER OF ANY YES ANSWERS AND EXPLAIN EACH ONE OF THEM IN THE SPACE BELOW.
Por favor, escriba aquí el número de las preguntas en las cuáles haya contestado que Sí y explique cada una de ellas en este espacio.

I certify that, to the best of my knowledge, the information provided above is complete and correct. Patient Signature: _____ Date:_____

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PATIENT AUTHORIZATION

Consent for Evaluation and Treatment

I hereby authorize Chicago Primary Care Sports Medicine (which for the purposes of this authorization includes its physicians, employees, and designated agents, hospitals or laboratories) to perform a physical examination and/or any medical treatment deemed necessary by the treating physician(s). These may include, but not be limited to, any required medical examinations, x-rays, medical procedures, and medical, diagnostic, or laboratory tests ordered by the physician to be carried out by designated staff.

Assignment of Benefits

I hereby authorize and assign to Chicago Primary Care Sports Medicine any and all benefit payments for services rendered under the terms of my insurance policies, and hereby individually obligate the payer to pay the account to Chicago Primary Care Sports Medicine in accordance with the standard and customary charges incurred during my period of treatment.

Financial Agreement

I understand that I am responsible for all deductibles, co-pays and charges for services rendered to me but not covered by my insurer. If I am liable for payment, a list of charges will be made available to me within thirty (30) days from the date Chicago Primary Care Sports Medicine becomes aware of my insurance ineligibility. Should the account be referred for collection, the undersigned shall pay the collection expenses incurred by Chicago Primary Care Sports Medicine including, without limitation to, court costs and attorney's fees.

Patient Name: _____

Patient or Legal Representative Signature: _____

Relationship to Patient: _____

Date: _____

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COMMUNICATION

I wish to be contacted by:

☐ Email: _____
(Preference #___)

☐ Telephone: _____
(Preference #___)

☐ Mail: _____
(Preference #___)

The following individuals are authorized to receive complete information about my diagnosis and treatment:

☐ _____ Relationship _____ Contact # _____

☐ _____ Relationship _____ Contact # _____

☐ _____ Relationship _____ Contact # _____

☐ _____ Relationship _____ Contact # _____

Patient Name: _____

Patient or Legal Representative Signature: _____

Relationship: _____

Date: _____

Chicago Primary Care Sports Medicine
Financial Policy

Thank you for choosing Balu Natarajan, MDSC as your health care provider. We appreciate your trust in us and are committed to providing you with the best care possible. Please understand that payment of your bill is considered part of your treatment. Please feel free to contact us at 312-616-7778 if you have any questions.

PPO INSURANCE/SUPPLIES

We participate with most major insurance companies. As the owner of your policy, you are responsible for verifying that we are an in-network provider under your plan. You are responsible at the time of service for all co-pays, balances, deductibles, providing us with co-insurance information, orthopedic supplies and other services not covered by your plan. In order to bill your insurance directly, **we must have a copy of your current insurance card**.

CHANGE OF INSURANCE

It is your responsibility to provide our office with any insurance changes. Claims denied due to "untimely filing" will be your responsibility if we were not initially provided with the correct billing information.

HMO (Health Maintenance Organization)

You are responsible for obtaining referrals for all visits and services. If you choose to see us without a valid referral, you will be financially responsible for all charges. We will provide you with an itemized statement for reimbursement purposes. **Copays and balances are due at the time of service**.

SELFPAY

Payment in full is due at the time of service unless prior arrangements have been made. We accept cash check, Visa, Mastercard and American Express.

MEDICARE and PUBLIC AID

We accept Medicare assignment. As a Medicare patient, you are responsible for the deductible. We will file any secondary insurance claims as long as you provide the secondary insurance information. If you have Public Aid, you must bring a referral from your primary care physician**. Copay is due at time of service.**

WORKERS COMPENSATION

If you are seeing us due a work-related injury, you must provide us with both your individual health insurance, Worker's Compensation insurance information, name of the WC claim adjustor and phone number, claim number and mailing address for claim.

RETURNED CHECKS

There will be an additional $30.00 charge for returned checks.

CANCELLATION POLICY

If you need to cancel or reschedule your appointment, **please give us at least 24 hours notice or you will be subject to a cancellation fee of $50.00**

MEDICAL RECORDS

Your medical records are held in strictest confidence. We require written authorization to release medical records and billing statements. If you request a copy of your medical records, you will be charged the standard processing fee. Standard processing fees will also apply for medical records and billing statements that are requested by your lawyer and for your individual insurance applications.

I understand that Balu Natarajan MDSC will bill my insurance carrier as a courtesy to me. I agree to provide all information that is needed by my insurance carrier or Balu Natarajan MDSC to facilitate payment for services rendered to me. I understand that I am ultimately responsible for payment of all services.

PRINT Name	Signature of Patient	Date
Print Name of Authorized Representative	Signature	Date

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chicagosportsmd.com

Acknowledge of Receipt of Notice of Privacy Practices

I,_____,

have received the Notice of Privacy Practices from Chicago Primary Care Sports Medicine.

X_____ Date:_____

In lieu of patient signature, I,_____,

a staff member of Chicago Primary Care Sports Medicine, state that _____

has been given our current Notice of Privacy Practices.

X_____ Date:_____

NOTICE OF PRIVACY PRACTICES
(Medical)

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.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive and accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775