MARIAN ORTHOPEDIC & REHABILITATION CENTERS, S. C.
Dr. John J. O'Keefe
Fellow of AAOS

Patient Demographics

Patient Name: ______________________________ Date: ____________________

Social Security# ______________________________ Date of Birth: ____________________

Preferred Language: ____________________ Secondary Language: ____________________

Please circle: Sex: M or F Marital status: Single Married Divorced Widowed

Primary Home Address: ____

City: ____________________ State: ____________________ Zip Code: ____________________

Home Phone: ______________________________ Cell Phone: ____________________

Email: ____

Occupation: ______________________________ Employer: ______________________________

Work Phone: ______________________________

Primary Care Physician: ______________________________ Phone#: ____________________

Referring Physician/Provider: ______________________________ Phone#: ____________________

EMERGENCY CONTACTS

Name: ____________________ Phone: ____________________ Relationship: ____________________

Name: ____________________ Phone: ____________________ Relationship: ____________________

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INSURANCE & LIABILITY

Primary Insurance: ______________________________ Effective Date: ______________

Please Circle: **HMO PPO Other ID#:**__________________**Group#:**____________________

Name of Insured:____________________________ Relationship:____________________

Subscribers SS#:____________________________ Subscribers DOB: ________________

Address: __________________________________ City: _________________________

State:_____________________________________ Zip Code:______________________

Secondary Insurance (if applicable):______________________________ Effective: __________

Please Circle: **HMO PPO Other ID#:**__________________**Group#:**____________________

Name of Insured:____________________________ Relationship:____________________

Subscribers SS#: _________________________ Subscribers DOB: ________________

Address: __________________________________ City: _________________________

State:_____________________________________ Zip Code:______________________

Please Circle: Personal Injury Workmen's Compensation

Did your injury occur at work? (Please circle) | No | Yes - if yes, date of injury:________________
Is your injury from an auto accident? (Please circle) | No | Yes -if yes, date of injury:________________

Are you being represented by an attorney? (Please circle) No Yes
If yes- Name of Attorney:____
Phone:______________________Fax:_______________________

Workman's Compensation Carrier:______________________Claim#:____________________
Name of Adjuster:____________________________________Phone: ____________________
Email: ____ Fax:_______________________

4849 W. Fullerton Ave. Chicago, IL
T :(312)-326-6100 F: (773)725-0097

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PATIENT REVIEW OF POILICIES

HIPAA PRIVACY NOTICE
I have received and read a copy of Marian Orthopedic & Rehabilitation Centers, S.C. ("Marian") notice of Privacy Practices ("Notice").

By initialing I have read and understand the above________

Authorization to Release Information
I consent to the use or disclosure of my protected health information by Marian for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Marian. As mentioned in Sections of the Notice.

By initialing I have read and understand the above________

Disclosures
I acknowledge that I have been notified that some or all the providers at Marian may or may not carry medical Malpractice Insurance. I also acknowledge that I have been notified that the providers at Marian may be involved in education, research, development, and / or consulting with regards to orthopedic products and the Orthopedic industry, therefore, the providers may benefit directly or indirectly from such educational, research, development, and or consulting relationships. The above does not conflict with my best interest as a patient at Marian. I desire to enter into a doctor-patient relationship with a provider at Marian as mentioned in (Section VI) of the notice.

By initialing I have read and understand the above________

Financial Agreement & Payment Policy
I understand that I am financially responsible for services rendered by Marian providers. I also understand that few insurance carriers cover all costs for services rendered. Marian will submit claims to my insurance carrier. I will be responsible for the balance on my account that my insurance carrier does not cover. I will pay any co-payments, co-insurance, and deductibles at the time of services at Marian. As mentioned in (Sections VII, VIII) in the notice.

By initialing I have read and understand the above________

Authorization for treatment
I hereby authorize the medical staff of Marian to render medical services and treatments as deemed necessary.

By initialing I have read and understand the above________

By signing, I have read, understand and agree to comply with Marian policies so noted in the Notice of Privacy Practices ("Notice").

Patient Printed Name: ____________________________________ Date: _____________________

If patient is a minor (under 18): Guardian Printed Name:____

Guardian signature:________________________________ Relationship:______________________________

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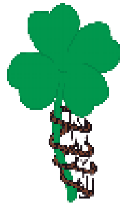

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Consent for the Release of Protected Health Information to Personal Representatives

I,______________________________, give my written consent for Marian Orthopedic & Rehabilitation Centers, S.C. to share information regarding my protected health information and care to the following below listed persons; I understand that these persons will be treated as personal representatives ofmyself.

Personal Representatives that Marian Orthopedic & Rehabilitation Centers, S.C. may share my protected Health Information with:

Name:____Relationship:___________________

Name:____Relationship:___________________

Name:____Relationship:___________________

_____Do not discuss my Protected Health Information with anyone other than myself.

Today's Date:________________________ Patient Signature:____________________________________

Marian Orthopedic & Rehabilitation Centers, S.C. may leave a message to return the call:

1. On VoiceMail__________ DO NOT Leave Message____________
2. At Home __________ DO NOT Leave Message____________
3. At Work __________ DO NOT Leave Message____________
4. By Email __________ DO NOT Leave Message____________

Patient Signature authorizing the above:____

Date of Birth: ________________________ Today's Date: ______________________

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REFERRAL DISCLOSURE

In the course of your treatment, physical therapy, an x-ray, MRI, CT, bone scan, bone density scan, or other ancillary services may be necessary and ordered. Marian Orthopedic & Rehabilitation Centers, S.C ("Marian") in accordance with the State Law, informs you that it is your choice to have the service done at our facility or at the facility of your preference, a list of such facilities in the area is provided below for your reference

Chicago	Schaumburg
1. MRI LINCOLN IMAGING 4849 W. Fullerton Ave., IL 60639 T: (773) 237-2900 **2. HERMOSA MEDICAL &DIAGNOSTIC CENTER** 2004 N. Pulaski Rd., Chicago, IL 60639 T: (773) 772-8876 **3. PREFERRED OPENMRI** 4200 W. 63rd St. Chicago, IL 60629 T: (773) 581-5600 **4. MIDWEST OPENMRI** 7810 W North Ave., Elmwood Park, IL 60707 T: (708) 452-2222	**1. AMITA MEDICALGROUP** 347 W. Golf Road, Schaumburg IL 60195 T: (847) 252-8820 **2. NORTHWEST COMMUNITYHOSPITAL** 519 S, Roselle Rd. Schaumburg IL 60193 T: (847) 985-0600 **3. SCHAUMBURG IMMEDIATECARE** 1375 E. Schaumburg, Schaumburg IL 60193 T: (847) 891-6850 **4. PREFERRED OPEN MRIELGIN** 1550 Todd Farm Dr. Elgin IL 60123 (224) 407-2149

SELF-REFERRAL DISCLOSURES

In the course of your treatment, physical therapy, an x-ray, MRI, CT, bone scan, bone density scan, or other ancillary studies may be necessary and ordered. **Marian in accordance with Illinois laws, informs you that you may request or receive a referral for these services outside and independent of Marian.**

I understand that Marian does not endorse or recommend any of the above suppliers, undertakes no obligations and makes no representations as to types or quality services any of these suppliers may provide.

Please print and sign your name below to acknowledge your understanding of the above statements.

____

Patient Name (printed)

____ ________________________

Patient Signature **Date**

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Fellow of AAOS

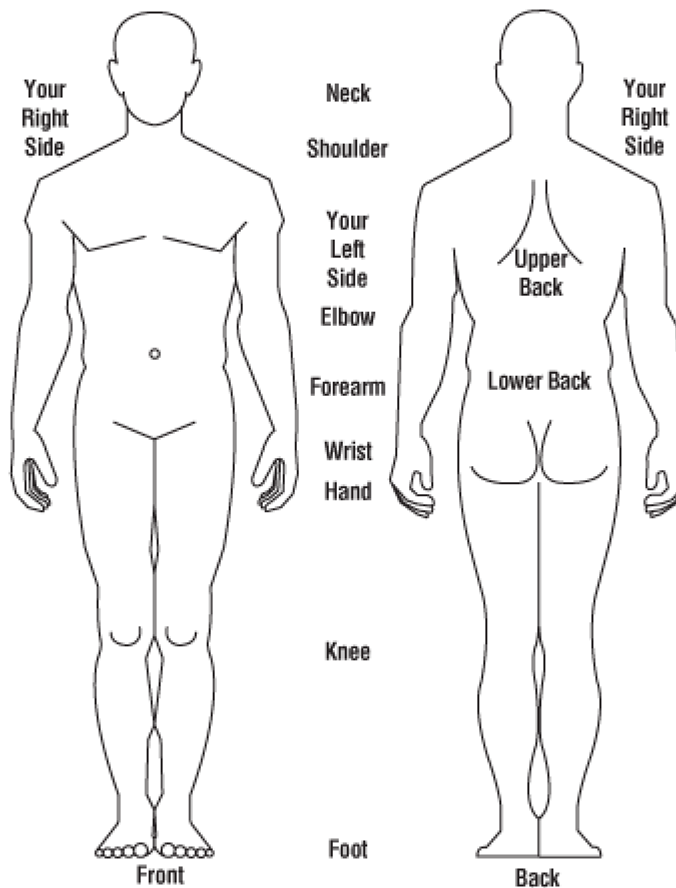
Name/Nombre: ______________________________

Today's Date/ Fecha:__________________ Date of Birth / Fecha de Nacimiento:____________________

PAIN DRAWING/ DIBUJO DE DOLOR

Instructions: Mark these drawings according to where you are hurt

Instrucciones: Marque en estos dibujos donde tiene dolor



PAIN SCALE/NIVEL DE DOLOR → (0= no pain/ nohaydolor 10= worst possible pain/Maximodolor)

0 1 2 3 4 5 6 7 8 9 10

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