

ORTHOPAEDICS & RHEUMATOLOGY OF THE NORTH SHORE

EDWARD L. SCLAMBERG, MD

WILLIAM J. ARNOLD, MD

STEVEN G. SCLAMBERG, MD

ERIN ARNOLD, MD

ALL SECTIONS MUST BE COMPLETED

(A new form must be completed every 12 months per insurance regulations)

PATIENT REGISTRATION

Last Name:		First Name:		Date of birth:	
Social Security #:			Marital Status:		
Home Phone #:			Cell Phone#:		
Address:		City:	State:	Zip code:	
Email address:					
Race:			Ethnicity:		
Primary Language:			Secondary Language:		
Pharmacy Name:					
Pharmacy Address:				Phone: - -	
Primary Care Physician:					
PCP Address:				Phone: - -	

PATIENT INFORMATION

Are you retired? YES NO

Employer:		Work Phone #:	
Patients Occupation:			
Address:		City:	State: Zip code:
Is your present condition related to an accident? YES NO		If yes date of accident:	
Work related: YES NO	Auto accident: YES NO	State accident occurred:	

WORKMANS COMPENSATION INFORMATION

Insurance Name:			
Address:		City:	State: Zip code:
Contact Person:		Phone #:	
Claim #:			

SPOUSE OR PARENT/GUARDIAN REGISTRATION TO THE INSURED (If not patient)

Name:		Social Security #:	
Address:		City:	State: Zip code:
Date of birth:	Retired: YES NO	Relationship to patient:	

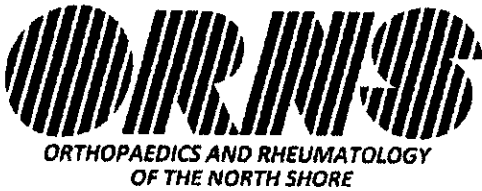
CONTACT PERSON IN CASE OF EMERGENCY

Name:	Relationship:	Phone#:
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I acknowledge receipt of notice of privacy practices (HIPAA).
 I authorize release of medical information.
 I authorize payment of medical benefits to the physician.
 I authorize the physician to provide treatment.

Patient signature:

Date:



ORTHOPAEDICS
EDWARD L. SCLAMBERG, M.D.
STEVEN G. SCLAMBERG, M.D.
4709 W. GOLF RD, SUITE 1200
SKOKIE, IL 60076

RHEUMATOLOGY
ERIN L. ARNOLD, M.D.
WILLIAM J. ARNOLD, M.D.
PHONE: 847-869-7233
FAX : 847-869-9461

ACKNOWLEDGMENT OF RECEIPTS OF NOTICE OF PRIVACY PRACTICES

**** You may refuse to sign this acknowledgement ****

I, _____ have read/received a copy of this office's
(Please print name)
Notice of Privacy Practices.

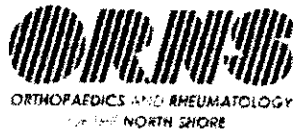
 _____
(Signature)

____/____/____
(Date)

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices but acknowledgement could not be obtained because :

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency prevented us from obtaining acknowledgement
- Other (please specify)



Acknowledgment of Receipt of Financial Policy

Patient Name: _____

DOB: ____/____/____

Thank you for choosing us as your care provider. We are committed to the successful treatment of your medical condition. Please understand that payment of your bill is considered part of your treatment. Your clear understanding of our Financial Policy is important to our professional relationship. Please call our office if you have any questions.

The patient, or legal guardian, is always responsible for payment. In consideration of services to be rendered, you, as the undersigned patient or guarantor for patient, agree to pay Orthopaedics and Rheumatology of the North Shore (ORNS) for all services and supplies provided to you (of the patient, as applicable) at the established rates, including any deductibles, co-payment or other charges, as permitted by third party payors. By signing this financial policy summary, you accept responsibility for any costs, including attorney's fees incurred by ORNS in the collection of these charges for examination, diagnosis and treatment received. Furthermore, you certify that the information given by you for purposes of payment is, to the best of you knowledge, complete and accurate.

Additionally:

- Full payment is due at the time of service for self-pay patients or if insurance information (and copy of insurance card) has NOT been provided.
- All patients must complete our "patient registration form" and other forms provided at the time of registration.
- If you would like us to bill your insurance directly, we MUST HAVE A COPY OF THE CURRENT INSURANCE ID CARD otherwise you will be billed.
- Please notify us immediately of any changes in your insurance information or coverage.
- At least 24 hours' notice is required for copies of medical records or x-rays and these may be a nominal fee.
- If you're here for a workers' compensation or accident claim, we will need your health insurance information and will bill that insurance if we do not receive proper documentation and/or payment from the workers' compensation or accident insurance carrier.
- You are ultimately responsible for payment of all services.

Medicare: We accept Medicare assignment. As a Medicare patient, you are responsible only for the difference between Medicare's approved charge and the amount Medicare pays, your deductible and charges for any service not covered by Medicare. If you have supplemental insurance, we will bill it directly for you. You will receive a bill after your insurance has paid.

HMO/PPO: ALL CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE. As the owner of your policy, you are responsible for verifying that we are an in-network provider under your plan. If you are an HMO member, you will not be billed as long as you have obtained the necessary referrals (also your responsibility).

Insurance Disputes: If there is a dispute regarding the payment of your insurance or certain workers' compensation claim, ORNS has the right to bill you prior to the resolution of that dispute and to anticipate payment from you.

I understand that the office agrees to bill insurance carrier as a courtesy to me. I must submit information as needed by my insurance company or ORNS to guarantee payment for services rendered to me. I understand that I am ultimately responsible for payment of all services.

X _____
Patient Signature

Print Name/Signature of Authorized Representative/Relationship

X _____
Date



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PHONE: 847-869-7233
FAX : 847-869-9461

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 was developed to protect patients' rights and confidentiality in a healthcare environment that is becoming increasingly more technologically advanced. It serves to protect patient privacy, secure health information and enhance standards to improve privacy protections and security safeguards for consumer health data.

Patient Name: _____ DOB: _____

I acknowledge that I have received notice of HIPAA privacy practices for ORNS, and I would like the below listed individuals to be allowed as approved contacts for my account. I acknowledge that you may speak with them in regards to my patient information, treatment/care, appointments, and billing. I understand that I may revoke this authorization and update these approved contacts at any time.

1. _____
(Name / Relationship)
2. _____
(Name / Relationship)
3. _____
(Name / Relationship)
4. _____
(Name / Relationship)
5. _____
(Name / Relationship)

At times, we will contact patients in regards to appointments, treatment, questions and care. If we are able to leave a voicemail for you if you do not answer at the time, please indicate to which phone numbers this would be allowed.

_____ cell _____ home
_____ work _____ other

Your Written Authorization is Required for Other Uses and Disclosures

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and
 2. Disclosures that constitute a sale of your Protected Health Information
- Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Your Rights:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to Orthopaedics & Rheumatology of the North Shore, attention Medical Records. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or

transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to Orthopaedics & Rheumatology of the North Shore, attention Supervisor.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to Orthopaedics & Rheumatology of the North Shore, attention Supervisor.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to Orthopaedics & Rheumatology of the North Shore, attention Supervisor. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless

the information is needed to provide you with emergency treatment.

Out-of-Pocket Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to Orthopaedics & Rheumatology of the North Shore, attention Supervisor. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, www.omsmd.com. To obtain a paper copy of this notice, please stop by Orthopaedics & Rheumatology of the North Shore.

Changes to This Notice:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

Complaints:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact the Practice Manager. All complaints must be made in writing. You will not be penalized for filing a complaint.

Orthopaedics & Rheumatology
of the North Shore
4709 W. Golf Road
Suite 1200
Skokie, Illinois 60076

Post Number # 1407158

NOTICE OF PRIVACY PRACTICES

ORTHOPAEDICS & RHEUMATOLOGY OF THE NORTH SHORE

4709 W. GOLF ROAD
SUITE 1200

SKOKIE, ILLINOIS 60076

Effective Date: September 23, 2013

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.

If you have any questions about this notice, please contact Orthopaedics & Rheumatology of the North Shore, at 847.869.9461 and request to speak to a supervisor.

Our Obligations:

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

How We May Use and Disclose Health Information:

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the orthopaedic care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives, and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a

disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

Special Situations:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Legal Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the

identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmate or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

ORTHOPAEDICS OF THE NORTH SHORE PATIENT MEDICAL HISTORY

Please answer all questions to the best of your ability. Date: _____

Name: _____ Age: _____

Height: _____ Weight: _____ Male _____ Female _____

Right handed _____ Left handed _____ Marital Status _____

History:

1) What problem are you seeing the doctor for today? _____

If related to a limb, is it on the **Right** or **Left** side or both? _____

2) When did the problem begin? _____

3) Is this a result of an injury? **Yes** **No** If yes, explain? _____

4) Is your problem covered under Worker's Compensation? **Yes** **No**

5) Have you received any treatment for your problem? **Yes** **No**

If yes, what has been done for you? _____

Test or x-rays: _____

If so where were they done? _____

Did you bring them with you? **Yes** **No**

6) If an injury, is there any litigation pending? **Yes** **No**

Referral:

Who referred you to this office?

Name: _____

Address: _____

City: _____ State: _____

Phone: (____) _____

Who is your family physician?

Name: _____

Address: _____

City: _____ State: _____

Phone: (____) _____

Past/Present Medical History:

Have you been diagnosed or received treatment for?

Ailment	Please Circle		Treatment if answered yes:
1) High Blood Pressure	Yes	No	_____
2) Heart Disease	Yes	No	_____
3) Lung Disease	Yes	No	_____
4) Diabetes	Yes	No	_____
5) Ulcers	Yes	No	_____
6) HIV / AIDS	Yes	No	_____
7) Kidney Disease	Yes	No	_____
8) Urinary / Bladder Disease	Yes	No	_____
9) Skin Disease	Yes	No	_____
10) Blood Disorder	Yes	No	_____
11) Disease of Nervous System	Yes	No	_____
12) Numbness in arms or legs	Yes	No	_____
13) Back / Neck problems	Yes	No	_____
14) Psychiatric Disorder	Yes	No	_____
15) Rheumatoid / Osteoarthritis	Yes	No	_____
16) Hepatitis A, B, C	Yes	No	_____
17) Cancer	Yes	No	_____
18) Other Problem Not Listed	Yes	No	_____

PAST SURGICAL HISTORY:

Have you ever had previous surgery? Yes No
If yes:

SURGERY	YEAR	SURGEON	HOSPITAL	COMPLICATIONS

Social History:

1) Tobacco use: **Yes** **No** If yes, number of years? _____

2) Alcohol use: **Yes** **No** If yes, how much? _____ How frequent? _____

Past History:

1) Have you ever had a blood transfusion? **Yes** **No**

2) Have you ever had a problem with anesthesia? **Yes** **No**
If yes, please explain: _____

3) Have you ever had a blood clot in your leg or lung? **Yes** **No**

4) Allergies to medicines? **Yes** **No**

If yes, please list: _____

5) Do you take any medications? **Yes** **No**

If yes:

MEDICATION	DOSAGE	TIMES TAKEN PER DAY

6) Pharmacy (name/city/zip): _____ Phone: _____

Past Family History:

1) Is there any useful family history relating to your problem? **Yes** **No**

If yes, please explain: _____

2) Is your **mother** alive or deceased? _____

If she is deceased, what was the cause of death? _____

3) Is your **father** alive or deceased? _____

If he is deceased, what was the cause of death? _____

NAME: _____

DATE: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

***PLEASE CIRCLE**

PAIN SCALE: 0 1 2 3 4 5 6 7 8 9 10

CONSTITUTIONAL:

Recent illness	YES	NO
Night sweats	YES	NO
Chills	YES	NO
Fever	YES	NO

MUSKULOSKELETAL:

Swelling	YES	NO
Joint complaint	YES	NO
Stiffness	YES	NO
Muscle weakness	YES	NO

CARDIOVASCULAR:

Chest pain/pressure	YES	NO
Edema	YES	NO
Palpitations	YES	NO

RESPIRATORY:

Wheezing	YES	NO
Cough	YES	NO

PSYCHIATRIC:

Alcohol abuse	YES	NO
Drug abuse	YES	NO

GASTROINTESTINAL:

Diarrhea	YES	NO
Nausea	YES	NO

HEMATOLOGIC:

Abnormal bleeding/bruising	YES	NO
On Coumadin/blood thinner	YES	NO

ALLERGY/IMMUNOLOGY:

Anaphylactoid reaction	YES	NO
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DERMATOLOGIC:

Rash	YES	NO
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CURRENT PHARMACY:

Name: _____

Address: _____

Phone: _____

PATIENT SIGNATURE: _____