	Patient Name:		DOS:	

New Patient Registration

First Name																								
Last Name																								

Social Security No.				-			-					**Date of Birth**			-			-						

Address																								

City												**State**			**Zip**									

Telephone No.				-				-			

Consent for Treatment

I hereby authorize employees, agents and providers (i.e., physicians, physical therapists, physical therapist assistants, physician assistants and nurse practitioners) of this medical facility to render routine medical evaluations and care to the patient whose signature appears on this form. This authorization includes fulfilling the orders of the medical provider(s) by consultants, associates and assistants of the physician's choice.

The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be medically evaluated or provided medical care except in a case of emergency.

I understand that by signing this authorization, I agree to allow this medical facility's employees, agents and providers to release any information obtained through the medical evaluations and care to the employer, insurance industry and legal profession, depending on the requesting source and in accordance with state and federal laws.

_____ _____

Printed Name of Patient, Parent or Legal Guardian Date

_____ _____

Signature of Patient, Parent or Legal Guardian Date

If Patient is a minor

I Consent for (Patient Name) _____ to authorize evaluation and treatment for the child herein when I am not available. I understand this authorizes the person(s) named to medical and surgical procedures and immunizations

	Patient Name:		DOS:	
IWIRC Illinois Work Injury Resource Center				

Medical History

Does your history include any of the following?

Please check Yes or No to all following questions and circle all that applies below:

Do you have a medical history of:	Y	N		Y	N
Anemia or Blood Disease?			Kidney Stones / Gall Stones?		
Asthma or Emphysema?			Kidney or Bladder Infections?		
Arthritis ?			Liver Problems or Disease?		
Broken Bones?			Peptic Ulcer, Black Stools, Heartburn or GERD?		
Cancer / Tumors?			Pneumonia or Pleurisy?		
Chest Pain or Angina?			Have Weakness or Fatigue?		
Diabetes or Hypoglycemia?			Shortness of Breath?		
Eye Trouble, Glasses or Contacts?			Nervous or Mental disease or Disorder?		
Fainting Spells or Blackouts?			Epilepsy or Seizures?		
Frequent migraines / headaches?			Stomach, Gallbladder, or Intestinal Trouble?		
Frequent Colds or Persistent Cough?			Painful, Frequent or Bloody urination?		
Frequent Sore Throat or Sinuses?			Sugar or Protein in Urine?		
Frequent Ear Infections or Deafness?			Major illness or hospitalizations?		
Glandular Disease? I.E. Thyroid or Pituitary			Seasonal Allergies or Hay fever?		
History of Blood Clots, Strokes, TIA?			Varicose Veins or Ankle Swelling?		
Heart or Coronary Artery Disease?			Recent weight gain / loss?		
Head Injury / Concussion / Loss of Consciousness?			Surgeries or Operations?		
Heart Murmur or Rheumatic Fever?			Skin Disease or Rashes?		
Hernia or Rupture?			Have you ever had a work-related injury?		
High or Low Blood Pressure?			Have you ever lost time from a work-related injury?		
Infectious Disease? (TB, Hepatitis, syphilis, Typhoid Fever)			Do you consume alcoholic beverages? Daily? Weekly? Socially?		
Hemorrhoids or Rectal Bleeding?			Do you now or have you ever smoked? How long? How many packs?		
Been under the care of a physician for any reason in the past 5 years?			Low back pain or history of back problems?		
Joint, Tendon, Muscle Pain?			Neck Pain or history of neck pain or problems?		
Numbness, Tingling of hands/fingers or history of carpal/cubital tunnel?			Last Tetanus (TD): Tuberculin (TB): Hepatitis B:		
Any other medical conditions or problems not listed?			FEMALE ONLY: Do you suffer from heavy cramping or periods that cause you to miss work ?		
Age			Are you or do you think you may be pregnant?		
NAME OF YOUR PRIMARY CARE PROVIDER?					
Explain any “YES” from above (if there’s not enough room please turn this page over and write on the back):					

I hereby certify that all the information I have furnished on this form is true and correct. I authorize the examining physician to disclose to the company any or all of my medical information, findings from the exam, or testing performed by the provider for the purpose of processing my examination for employment or service with the company. I willingly submit to any required test necessary to complete this examination.

_____ _____

Applicant’s Signature Date

	Patient Name:		DOS:	

Illinois Work Injury Resource Center HIPAA

Who will follow this notice?

The Illinois Work Injury Resource Center, IWIRC, provides health care to our clients in partnership with physicians and other professionals and organizations. The information privacy practices in this notice will be followed by all health care professionals, employed associates, staff, business associates or volunteers who treat you at any of our locations.

Our pledge to you.

We understand that medical information about you is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive to provide quality care and to comply with legal requirements. This notice applies to all of the records of your care that we maintain, whether created by facility staffer or if a doctor may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office.

We are required by law to keep medical information about you private, give you this notice of our legal duties and privacy practices with respect to medical information about you, and follow the terms of the notice that are currently in effect.

Changes to this notice.

We may change our policies at any time. Changes will apply to medical information we already hold, as well as new information, after the change occurs. You can receive a copy of the current notice at any time. The effective date is listed just below the title. You will be offered a copy of the current notice each time you register at our facility for treatment. You will also be asked to acknowledge in writing your receipt of this notice.

How we may use and disclose medical information about you.

We may use and disclose medical information about you for treatment (such as sending medical information about you to another health care facility or to a specialist as part of a referral); to obtain payment for treatment (such as sending billing information to your insurance company or, in the case of workers compensation, your employer); and to support our health care operations (such as comparing patient data to improve treatment methods).

We may use or disclose medical information about you without your prior authorization for several other reasons, such as public health purposes, abuse or neglect reporting, health oversight audits or inspections or workers' compensation purposes, and emergencies. We also disclose medical information when required by law, such as in response to a request from law enforcement in specific circumstances, or in response to valid judicial or administrative orders. We also may contact you for appointment reminders, or to tell you about or recommend possible treatment options, alternatives, health-related benefits or services that may be of interest to you. We may disclose medical information about you to a friend or family member who is involved in your medical care or to disaster relief authorities so that your family can be notified of your location and condition. Our workers will use their professional judgment in determining what they disclose, and to whom, based on their evaluation of your best interests.

Notice of Privacy Practices

Other uses of medical information.

In any other situation not covered by this notice, we will ask for your written authorization before using or disclosing medical information about you. If you chose to authorize use or disclosure, you can later revoke that authorization by notifying us in writing of your decision.

Your rights regarding medical information about you.

In most cases, you have the right to look at or get a copy of medical information that we use to make decisions about your care, when you submit a written request. If you request copies, we may charge a fee for the cost of copying, mailing or other related supplies. If we deny your request to review or obtain a copy, you may submit a written request for a review of that decision. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we amend the records, by submitting a request in writing that provides your reason for requesting the amendment. We may deny your request to amend a record if the information was not created by us; if it is not part of the medical information maintained by us; or if we determine that the record is accurate. You may appeal, in writing, a decision by us not to amend a record.

You have the right to a list of those instances where we have disclosed medical information about you, other than for treatment, payment, health care operations or where you specifically authorized a disclosure, when you submit a written request. The request must state the time period desired for the accounting, which must be less than a 6-year period and starting after April 14, 2003. The first disclosure list request in a 12-month period is free; other requests will be charged according to our cost of producing the list. We will inform you of the cost before you incur any costs. You have the right to request that medical information about you be communicated to you in a confidential manner, such as sending mail to an address other than your home, by notifying us in writing of the specific way or location for us to use to communicate with you.

You may request, in writing, that we not use or disclose medical information about you for treatment, payment or health care operations or to persons involved in your care except when specifically authorized by you, when required by law, or in an emergency. We will consider your request but we are not legally required to accept it. We will inform you of our decision on your request. All written requests or appeals should be submitted to our Privacy Office listed at the end of this notice.

Complaints.

If you are concerned that your privacy rights may have been violated, or you disagree with a decision we made about access to your records, you may contact our Privacy Office, **IWIRC Privacy Office, 736 SW Washington St., Suite 2A, Peoria, IL 61602, 309-497-0300**. Finally, you may send a written complaint to the U.S. Department of Health and Human Services Office of Civil Rights. Our Privacy Office can provide you the address. Under no circumstance will you be penalized or retaliated against for filing a complaint.

I hereby acknowledge that I have read this document and understand its contents.

Signature_____ Date_____

	Patient Name:		DOS:	
IWIRC Illinois Work Injury Resource Center				

RELEASE

I, or my employer, have requested evaluation and/or treatment at **IWIRC** including: diagnostic procedures, medical evaluation and treatment, and surgical evaluation and treatment. I permit **IWIRC** doctor(s) and other providers to treat me in ways they judge are beneficial to my care.

No one has given me any guarantees about how these examinations and treatments will affect my condition or me.

If I refuse medical care recommended by the **IWIRC** doctor, **IWIRC** and the doctor are relieved of any responsibility for any ill effects, which might result from my action.

If I am referred to another doctor, I understand, I must seek continuing medical care from that doctor or another of my choice. If I am referred for therapy services, I understand that I will be offered those services at **IWIRC**. If I want to receive the specific services requested by the **IWIRC** medical provider with another therapy provider, such as Professional Therapy Services, I understand that it is it is my responsibility to inform the medical provider during my appointment.

ASSIGNMENT OF INSURANCE

I understand I, or my employer, is financially responsible for charges not covered by this assignment. In the event a work related injury is later determined not be work related, I hereby assign to **IWIRC** my insurance benefits and authorize payment directly to **IWIRC** thereof but not to exceed the regular charges for services provided.

RELEASE OF INFORMATION

I authorize **IWIRC**, upon my written permission, to release portions of my records necessary for billing purposes along with determinations of my fitness for work.

I understand that all or portions of my medical record, in cases related to workers' compensation could be released to my employer, to me or my dependents, or attorneys involved in my case upon written request for such information.

This authorization includes, but is not limited to my employer, insurance companies, unemployment, and workers' compensation carriers and the Social Security Administration or its intermediaries.

_____ _____

Patient Signature Date