elevate

Patient Information			
Last Name	First Name	MI	Date of Birth
Occupation	Marital Status ☐ S ☐ M ☐ W ☐ O	Sex ☐ M ☐ F ☐ O	
Address	City	State	Zip
Home Number	Mobile Number	Email	
Employer Name (Required for Worker's Comp Patients)	Employer's Phone Number	Employer's Contact Name	
Preferred Method of Contact: ☐ Home Number ☐ Mobile Number ☐ Email			

Emergency Contact		
Primary Emergency Contact Name	Phone Number	Relation to Patient
Secondary Emergency Contact Name	Phone Number	Relation to Patient

Referral Information	
Referring Physician Name	Referring Physician Phone Number
Referring Physician Address	
Primary Care Physician Name	Primary Care Physician Phone Number
Primary Care Physician Address	
Patient or Parent/Guardian Signature	**Date**

Insurance Information		
Primary Insurance Name		Primary Insurance Phone Number
Member/Subscriber ID Number	Group Number	Relation to Patient
Name of Insured (If other than patient)		Date of Birth of Insured (If other than patient)
Secondary Insurance Name		Secondary Insurance Phone Number
Member/Subscriber ID Number	Group Number	Relation to Patient
Name of Insured (If other than patient)		Date of Birth of Insured (If other than patient)

Worker's Comp Complete this section if your injury/condition is related to a work injury.	
Worker's Comp Insurance Carrier	Worker's Comp Insurance Carrier Phone Number
Claim Number	Accident Date
Adjustor's Name	Adjustor's Phone Number

Auto Insurance Complete this section if your injury/condition is related to an auto accident.	
Auto Insurance Carrier	Auto Insurance Carrier Phone Number
Claim Number	Accident Date
Adjustor's Name	Adjustor's Phone Number

Consent to Physical Therapy Evaluation and Treatment

Physical Therapy is a patient care service that is provided in order to manage and treat a wide variety of conditions. Services are provided to individuals of all ages regardless of gender, ethnicity, creed, national origin, or disability.

The purpose of physical therapy is to prevent and treat disease, injury, and disability through examination, evaluation, diagnosis, prognosis, and intervention by use of rehabilitative procedures, mobilization of joints and soft tissues, manipulation, exercises, patient education, and physical agents to help the patient reach their greatest potential within their capabilities, to accelerate convalescence, and to reduce the length of functional recovery. All procedures will be thoroughly explained to you as needed and requested before you are asked to perform or participate in them.

Response to physical therapy intervention varies from person to person, hence it is not possible to accurately predict your response to a specific procedure, exercise protocol, or modality. Elevate Physical Therapy Partner LLC does not guarantee what your reaction will be to a specific treatment, nor does it/she guarantee that the treatment will help resolve the condition for which you are seeking treatment. Furthermore, there is a possibility that the physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury.

It is your right to decline any part of your treatment at any time before or during treatment, should you feel any discomfort, pain, or have other unresolved concerns. It is your right to ask your physical therapist about the treatment they have planned based on your individual history, physical therapy diagnosis, symptoms, and examination results. Consequently, it is your right to discuss the potential risks and benefits involved in your treatment.

I have read this consent form and understand the potential risks involved in physical therapy. I understand that the success of my treatment depends on my ability and willingness to cooperate and participate in all physical therapy procedures and comply with the established plan of care.

By my signature below, I certify that I have read, understand, and fully agree to the statement in this section and sign below freely and voluntarily.

Patient or Parent/Guardian Signature	**Date**

Reassignment of Benefits

I authorize payment of medical benefits to Elevate Physical Therapy Partners LLC for services rendered. Elevate Physical Therapy Partners LLC will make reasonable effort to collect insurance proceeds by completing insurance forms and sending them to the insurance company. Completion of such forms and/or the acceptance of assignment of insurance benefits does not relieve the undersigned of the obligation to pay the amount owed for services rendered.

By my signature below, I certify that I have read, understand, and fully agree to the statement in this section and sign below freely and voluntarily.

Patient or Parent/Guardian Signature	**Date**

Financial and Cancellation Policy

ALL PAYMENTS ARE EXPECTED AT THE TIME OF SERVICE

Please note, all payments for deductibles, co-insurances, and/or co-payments as well as payment for self-pay services are due at time of service. All patients are required to keep a debit/credit and FSA/HAS account on file.

Note that payments made at time of service are for an estimated amount based on the benefit information provided by your insurance company, and not the exact amount you will owe for any given date of service. Final dollar amount due for services will be determined after your insurance processes your claim. (This statement is not applicable to self-pay patients).

The clinic accepts cash, personal checks (in-state only), VISA, MasterCard, and Discover. There is a $25.00 service charge for returned checks. Also, please note that any payments that we need to process using your card on file will incur a 2.75% processing fee.

Patients with an outstanding balance 60 days or older may be forwarded to a third-party collection agency.

INSURANCE

Our office will check your benefits as a courtesy to you and provide this information on or before your first appointment. The benefit information we will provide for you is only a quote of benefits, so it is not a guarantee that we will receive payment from your insurance company for services rendered. The actual benefit for services provided will be determined by your insurance once they receive your claim.

We bill your insurance companies as a courtesy to you. You are expected to pay your deductible, co-insurance, and/or co-payment at the time of service. If we have not received payment from your insurance company within 60 days of the date of service, you may be expected to pay the balance in full. Please note, even though we will bill your insurance carrier, you are still responsible for payment of all services rendered whether by you or your insurance company.

SELF-PAY

Our patients have the option to self-pay for physical therapy services. If you opt to self-pay, you agree to the following pricing:

30min visit $100
45min visit $150
60min visit $200

CANCELLATION AND NO-SHOW POLICY

Please contact our office if you cannot come to a scheduled appointment. If you do not call 24 hours prior to your scheduled appointment time, there will be a $50 late cancellation fee. Failure to call or show for a scheduled appointment will result in a $75 no-show fee.

By my signature below, I certify that I have read, understand, and fully agree to the statement in this section and sign below freely and voluntarily.

Patient or Parent/Guardian Signature	**Date**

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Medical History Form

Name_____ Date Symptoms Began_____

In a few words, describe your symptoms _____

_____

Are your symptoms related to an accident? ☐Y ☐N If yes, please describe the accident_____

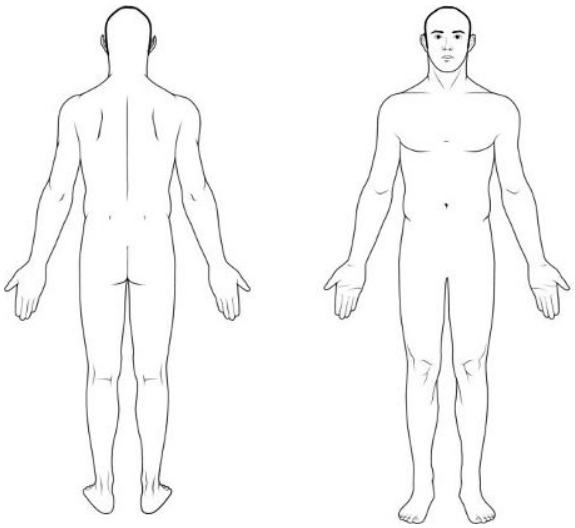
_____

Did your illness/injury require surgery? ☐Y ☐N If yes, please provide the date of surgery_____

Have you been diagnosed with any of the following conditions?
Check all that apply:

- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Pressure Problems
- ☐ Fractures
- ☐ Convulsions
- ☐ Diabetes
- ☐ Migraines
- ☐ Disc Trouble
- ☐ Fainting Spells
- ☐ Heart Disease
- ☐ Osteoporosis
- ☐ Pacemaker Implantation
- ☐ Paralysis
- ☐ Muscle Weakness Pregnancy
- ☐ Spine Issues
- ☐ Cancer Type _____
- ☐ Dizziness

In the diagram below, please indicate which where you have pain or symptoms



Other conditions _____

Did you have any diagnostic testing for your current condition?
☐X-rays ☐CT Scan ☐Bone Scan ☐ EMG ☐Nerve Conduction Study ☐MRI ☐Other

Rate your pain intensity and current/prior level of function. Rate your pain on a scale of 0-10. (0 being no pain).
Rate your current and prior level of function on a scale of 0% to 100% with 100% being you are fully functional

Pain
Current ___/10
At best ___/10
At worst ___/10

Function
Current_____/Prior_____

Patient or Parent/Guardian Signature	**Date**

Acknowledgement of Receipt of Notice of Privacy Practices	
I certify that I have received a copy of the Notice of Privacy Practices of Elevate Physical Therapy Partners LLC. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills, or in the performance of Elevate Physical Therapy Partners LLC health care operations. The Notice of Privacy Practices also describes my rights and Elevate Physical Therapy Partners LLC duties with respect to my protected health information. The Notice of Privacy Practices is also available at the front desk area and on the Elevate Physical Therapy Partners LLC at www.elevatephysicaltherapychicago.com. Elevate Physical Therapy Partners LLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, asking for one at the time of my next appointment, or accessing the Elevate Physical Therapy Partners LLC website.	
By my signature below, I certify that I have read, understand, and fully agree to the statement in this section and sign below freely and voluntarily.	
Patient or Parent/Guardian Signature	**Date**