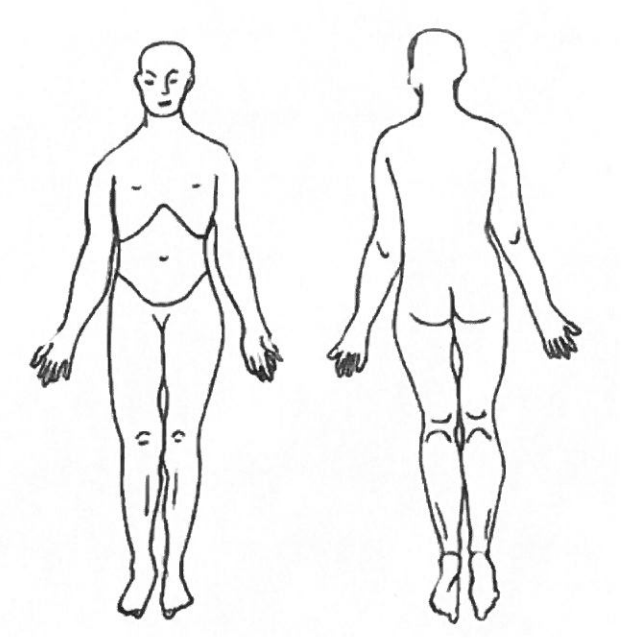
Physical Therapy Pre-Exam Questionnaire

Please indicate the location of your symptoms on the body diagram



Briefly describe your symptoms:

□ Aching	□ Constant
□ Sharp/Stabbing	□ Intermittent
□ Numbness	□ Burning
□ Tingling	□ Other

On the scale below, circle your **worst** pain the last couple of days:

Mild *Moderate* *Severe*

0 1 2 3 4 5 6 7 8 9 10

On the scale below, circle your **best** pain the last couple of days:

Mild *Moderate* *Severe*

0 1 2 3 4 5 6 7 8 9 10

Date of Birth ____/____/_____

What caused your pain/or problem? _____

Approximately when did it start? ____/____/_____

Is it getting worse, better, or staying the same? _____

Have you ever had this pain/problem before? (Circle) YES NO

Are any of your usual everyday activities affected? YES NO

If yes, describe how:

_____

List all past surgeries with dates:

_____

_____

List all medical conditions you have (or were told you have):

_____

_____

Please provide a list of all your current medications. (A photocopy of a printed list is acceptable).

_____

_____

_____

Patient signature

_____ _____

Patient name Date

Initials of P.T.

Patient Express Registration

Advanced Rehabilitation Clinics, Inc.

Today's Date:

1. Personal Info

Please Fill-Out Entire Form Completely & Legibly.

_____ _____ _____ ❑ Male ❑ Female

Last Name First Name Age

_____

Street Address City State ZIP

(_____)_____ (_____)_____

Home Phone Cellular Email Address (Important)

_____(_____)_____

Emergency Contact Person Phone # (if minor) Parent/Guardian Name and Signature

_____(_____)_____

Occupation Employer Name Phone #

My condition is related to: ❑ Work ❑ Auto Accident (State_____) ❑ Other_____

Social Security #_____ Date of Birth_____/_____/_____ ❑ Single ❑ Married

Work Status: ❑ Currently Employed: ❑ Retired ❑ Disabled/Off work (__Total or __Temporary) ❑ Student (__P/T __F/T)

2. Referral Info

ALL INFO REQUIRED

How did you hear about us? (Check all that apply)

- ❑ Brochure or Sign: (Location?) _____
- ❑ ARC Event: (Location?) _____
- ❑ Friend or Family: (Name?) _____

LifeStart Wellness:

- ❑ I am a Club Member
- ❑ Referral: (Name of Trainer?) _____

Online:

- ❑ ARC Website
- ❑ Facebook
- ❑ Insurance Website
- ❑ Search Engine
- ❑ Physician Referral: (Physicain Name) _____

(Physician Address) _____

(Physician Phone #) _____

- ❑ Other: _____

Do you have a followup appointment with this physician?_____

If yes, when? _____

3. Payment Info

(check only one box)

I am a Self-Pay patient and would like to . . .

- ❑ Pay at the time of service in full ***prior*** to each visit
- ❑ Pre-pay for multiple visits (pay for 5, get 6 visits, pay for 10, get 12 visits, etc.)
- ❑ Payment plan over time (Care Credit only - ***No Exceptions***).

I have INSURANCE and would like to . . .

- ❑ Have you deal directly with them. I will assign my benefits to you by completing the "Assignment of Benefits Form". Fees may apply. The following information is required prior to 1st visit.

My insurance/copay is _____

My co-insurance/copay is $_____

My deductible is $_____

4. Credit Card on FIle

Safe and Secure. I understand I will be notified of any and all charges prior to processing.

___Visa ___MC ___Discover Card #_____

Name on Card_____ Exp Date_____ CVV code_____

- ❑ I attest the information on this form is true and accurate, and do hereby agree and give my consent for Advanced Rehabilitation Clinics, Inc. to provide services to _____ that are considered necessary and proper. I further acknowledge that treatment is being provided to me solely by Advanced Rehabilitation Clinics, Inc., which is separate from and unaffiliated with the Lifestart Wellness Network. I hereby realize the Lifestart Wellness Network and its affiliates, and waive any and all claims against them, arising out of or relating to any act or omission of Advanced Rehabilitation Clinics, Inc, its agents or employees.

Assignment of My Benefits

For PPO, POS, and Private Third Party Payers

IMPORTANT: Please Fill Out This Form Completely and Legibly (Do no leave anything blank)

Patient Name: _____ ID#_____ DOB_____

Group # _____

Insured Name (if other than patient) _____ Insured Date of Birth_____

Your relationship to the Insured: ☐Parent ☐Spouse ☐Other_____

I hereby instruct and direct _____insurance company to pay by check made out and mailed to:

Advanced Rehabilitation Clinics, 183 N York St #A, Elmhurst, IL 60126

If my/this current policy prohibits direct payment to the doctor/therapist, I hereby also instruct and direct you to make out the check to me and **mail it to the above address** for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

This is a direct assignment of my rights and benefits under this policy.

This payment will not exceed my indebtedness to the above-named assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

(Check each box and sign at the bottom)

☐A photocopy of this Assignment shall be considered as effective and valid as the original.
☐I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.
☐I authorize the use of this signature on all insurance submissions.
☐ I authorize ARC Physical Therapy to deposit checks made in my name
☐I authorize ARC Physical Therapy to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
☐I understand I am financially responsible for all charges whether or not paid by insurance.

Dated this _____day of _____, 20 _____.

_____ _____

Signature of Policyholder Witness

_____

Signature of Claimant, if other than Policyholder

Important ARC Policies for a Successful Relationship

We strive to provide you the best personalized care available. To make this possible we adhere to a set of very important guidelines. Please read them carefully, initial all the boxes, and indicate your agreement by signing at the bottom.

PLEASE INITIAL EACH BOX.

☐ **Late Policy "10-minutes"**
Being late by more than 10 minutes will require you to either reschedule or wait for the next available opening. There are no guarantees since openings due to cancellations are unpredictable. We do not allow appointment overlap because this undeservedly compromises the care of another patient.

☐ **24-Hour Advance Notice Fee**
If you wish to change or cancel an appointment we require a minimum ***24-hour advance notice***. Anything less will result in a ***$50 fee charged to your account***. It costs us money to make appointments available to you. Whether you attend or not we still accrue the expenses (for staff wages, rent, etc.). We don't charge you the actual cost for that appointment but rather a mere **$50 fee**. We do NOT make money with this charge; it's only to act as a deterrent from making last minute changes. Advance notice allows someone else (who needs it) time to reserve it in place of you***. Please be courteous and responsible. It is your responsibility to pay this fee prior to your subsequent visit***. Thank you.

☐ **Copays are due upon arrival**
If you happen to forget your wallet or checkbook we may still be able to see you upon completion of an "Extension Request" form. This is a "promise-to-pay" form and carries a minimal fee that allows you to keep your appointment.

☐ **No-shows are bad**
If you fail to show for an appointment without notice all future appointments will be removed and a $50 fee assessed to your account. It is your responsibility to pay this fee prior to your subsequent visit. You may re-schedule appointments again on a "first come, first serve basis".

☐ **Cell phones must be shut OFF or silent**
We realize emergencies may arise and therefore allow you to carry your cell phone during your session, however, please be courteous and set your cell phone to silent mode or turn off. Thank you.

☐ **Children requiring supervision are NOT allowed to attend sessions with you.**
You may not bring children who require supervision with you to your appointment. If your child does not require supervision and is capable of waiting for you quietly then you may bring them. If any disturbance is caused to other patients or staff members you may be asked to terminate your session early and attend to your child.

☐ **Financial Hardship**
If you are experiencing financial difficulties and are unable to afford the cost of our services we have a "Financial Hardship Form" which may be filled-out. If you qualify for financial assistance according to the Federal guidelines, we may legally assist you by waiving or discounting your (patient responsibility) portions of the bill. Ask the front desk person for assistance.

☐ **Important Notice from the Federal Government:**
"It is unlawful to routinely avoid paying your copay, deductible or coinsurance payments . . . even if your doctor allows it. Unless you complete a "Financial Hardship" form and qualify for financial assistance under Federal Standards, you may NOT routinely evade paying your responsibility portions for medical care as outlined in your insurance plan even if your doctor allows it. You both may be charged for breaking the law. This includes services deemed as "professional courtesy" and "TWIP's - Take what insurance pays". Failure to comply places you in violation of the following laws: Federal False Claims Act, Federal Anti-Kickback Statute, Federal Insurance Fraud Laws, State Insurance Fraud Laws. Failure to comply may result in civil money penalties (CMP) in accordance with the new provision section 1128 A(a)(5) of the Health Insurance Portability and Accountability Act of 1996 [section 231(h) of HIPAA]. Exceptional cases do apply. Please see contact info for more information. Office of Inspector General, Department of Health and Human Services. Contact by by phone: 202 619-1343, by fax: 202 260-8512, by email: paffairs@oig.hhs.gov, by mail: Office of Inspector General, Office of Public Affairs, Department of Health and Human Services, Room 5541 Cohen Building, 333 Independence Avenue, S.W., Washington, D.C. 20201, Joel Schaer, Office of Counsel to the Inspector General, 202 619-0089."

☐ I have read and agree to all the policies on this form.

Signed _____ Date _____

ARC Physical Therapy

Cancellation/No Show Policy

At ARC Physical Therapy we feel strongly that our patient's time is valuable. When your appointment is made, time is set aside for you alone and preparations are made for your visit. Except for emergency treatment of another patient, you can expect us to be prompt. We, of course, would appreciate the same courtesy from you.

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, if you wish to cancel an appointment we require a minimum ***24 hour advance notice.*** Anything less will result in a ***$50 fee charged to your account.***

Because tardiness may affect patients scheduled after you, and because late changes in the schedule are unfair to those patients who have requested earlier appointments, we ask that you keep the following in mind:

1) If you are more than 15 minutes late, you might be asked to reschedule to later in the day, or to another day, depending on the flexibility of our schedule. It is important for you to be on time (or a few minutes early if it is your first visit).

2) We ask that you give us at least **24 hours notice** to cancel or reschedule an appointment. This will give us sufficient time to contact patients who have requested earlier appointments.

Please be courteous and responsible. If an appointment is not cancelled at least **24 hours** in advance you will be charged a **$50 fee**. ***This fee will not be covered by your insurance company. It is your responsibility to pay the fee prior to your subsequent visit.***

Thank you for taking time to review this information. We are happy to have you as our patient and look forward to assisting you.

_____ _____

Printed Name Signature

_____

Date

6/2015

Your Right to Amend Your PHI: If You disagree with what Your PHI in Our records says about You You have the right to request in writing that We amend Your PHI when it is in a record that We create or have maintained for Us. We are not required to respond to Your request if the records You are asking about are not Our records. We may refuse to make Your requested amendment. Then, You will have a right to submit a written statement about why You disagree. If We still disagree, We may prepare a counter-statement. Your statement and Our counter-statement must be made part of Our record about You.

Your Right to Know Who Else Sees Your PHI: You have the right to request an accounting of certain disclosures that We have made of Your PHI over the past six years. You cannot ask for disclosures before April 14, 2003. We do not have to account for all disclosures, including those involving treatment, payment, and health care operations as described above. We will tell You if there is a charge for Your accounting and You will have the right to withdraw Your request, or to pay to proceed.

Your Rights to Complain: If you believe that Your privacy rights have been violated, You have the right to make a complaint to Us, or to the Secretary of Health and Human Services. We will not retaliate against You if You file a compliant about Us. To file a complaint, You should submit it in writing to the contact person identified in this Notice. Your complaint should provide a reasonable amount of specific detail to enable Us to investigate a potential problem.

Some of Our Privacy Obligations and How We Perform Them

We are required to comply with the federal health information privacy regulations. Those rules require Us to protect Your PHI. Those rules also require Us to give You Notice of Our privacy practices. This document is Our Notice. If You did not get a paper copy of this Notice, You may have one. We will abide by the privacy practices set forth in this Notice. However, We reserve the right to change this Notice and Our privacy practices when permitted or as required by law.

Contact Information If You have questions about this Notice, or if You have a complaint, please contact:

Anita Lanute
Advanced Rehabilitation Clinics, Inc
Privacy Officer
183 N. York St Suite A
Elmhurst, IL 60126
Phone: 630-832-6919

Effective Date

This Notice takes effect on April 14, 2003.

I have read, understand and received a copy of this Privacy Notice.

_____ _____

Signature Date

HEALTH INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INORMATION. PLEASE REVIEW IT CAREFULLY.

About Protected Health Information-"PHI"

In this Notice, "We," "Our" or "Us" means the Chicagoland Physical Therapy, Ltd. and Our workforce of employees. "You" and "Your" refers to each of Our patients who is entitled to a copy of this Notice.

We are required by federal and state law to protect the privacy of Your health information. For example, federal health information privacy regulation requires Us to protect health information about You in the manner that We describe here. Certain types of health information may specifically identify You. Because We must protect this health information, We call this Protected Health Information—or "PHI." In this Notice, We tell You about:

- How We use Your PHI
- When We may disclose Your PHI to others
- Your privacy rights and how to use them
- Who to contact for more information or with a complaint

Some of the ways We use or disclose Your Protected Health Information

We will use Your PHI to treat You. We will use Your PHI and disclose it to get paid for Your care. We are allowed to use or disclose Your PHI for certain activities that We call "health care operations." Health care operations involve a lot of the administration, education, and quality assurance activities in Our clinic. Following are examples of the types of uses and disclosures that we are permitted to make.