PHYSICAL THERAPY
OF LAKE FOREST

Physical Therapy of Lake Forest 840 South Waukegan Road Lake Forest, Il 60045
(847) 455-6674

Patient Information

Name: ____
Last First MI

Address: ____
Street City State Zip code

Home Phone:____________________Work Phone:____________________Cell Phone: ____________________

Age:__________DOB:__________________Height:__________________Weight:__________________

Sex: Male / Female *(please circle)* email address: ____

Marital Status: Married / Divorced / Single / Widowed *(please circle)*

Emergency Contact:______________________________Phone: ______________________________

Employer Name:______________________________Occupation: ______________________________

How did you hear about Physical Therapy of Lake Forest*?*

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____

Brief Description of Injury or Surgery ____

____

Primary Care Physician:______________________________Phone: ______________________________

Referring Physician:______________________________Phone: ______________________________

Parent or Responsible Party *(if different than patient)*

Name:______________________________Relationship to Patient: ____________________

Street City State Zip code
Address: ____

Insurance Information:

Name of Policy Holder:______________________DOB:__________Phone #: ____________________

Address:______________________________Employer: ______________________________

Primary Insurance: ____

ID #:______________________________Group #:______________________________

Secondary Insurance: ____

ID #:______________________________Group #:______________________________

No-Fault Insurance:____________________Date of Accident:______________Claim #: ______________

Workers Compensation:____________________Date of Accident:______________Claim #: ______________

Consent to Treatment:

I consent to treatment provided by Physical Therapy of Lake Forest, LLC. I recognize that I have a condition requiring medical care and further acknowledge that I am aware and affirm that no guarantees have been made to me concerning treatment by Physical Therapy of Lake Forest,LLC.

Patient / Guardian Signature

Date

Cancellation and No-Show Policy

- **We require 24 hours' notice in the event of canceling a scheduled appointment.** When canceling an appointment please have an alternative time in mind in order to maintain the prescribed number of treatments for that week.

- **There is a $35.00 charge for a cancellation without proper notice or a No-Show.** As a courtesy to the patient we will waive the first cancellation without proper notice / no-show offense. In the event of a second offense we will expect payment prior to being seen for a subsequent visit.

I have read and understand the above policies and agree to the terms.

Signature of patient (or responsible party)

Date

Financial Policies and Agreement

- Payment is due when services are rendered unless other arrangements are made in advance.
- If your insurance (for example Medicare) requires a medical referral to cover the fees for PT services, you are responsible for obtaining any necessary referral / prescription. You will need to present the referral / prescription at the time of your initial evaluation.
- **Explanation of financial responsibility without insurance coverage:** I understand that if I am seen (with my acknowledgment) by Physical Therapy of Lake Forest, LLC without health insurance coverage, I am ultimately responsible for the balance on my account for any professional services rendered.
- **Commitment to make co-payment:** In order to comply with the rules and regulation of each health insurance company, co-payment must be paid at the time of service rendered.
- **Benefit Assignment:** You assign all medical benefits to Physical Therapy of Lake Forest, LLC including health insurance, Medicare, auto insurance, workers' compensation or other insurance plans. You authorize Physical Therapy of Lake Forest, LLC to release your medical records in order to process your claims.
- **Voluntary Termination of Care:** If your care is suspended or you terminate your care at any time, your portion of all charges for professional services will be immediately due and payable to Physical Therapy of Lake Forest, LLC. Financial Policies and Agreement continued:

Method of Payment: We accept cash, credit card and check. There is a $30.00 charge for any returned checks.

I have read and understand the above financial policy and agreement and agree to the terms therein.

Signature of patient (or responsible party)

Date

Notice of Privacy Practices and Compliance Measures for Physical therapy of Lake Forest, LLC

Physical Therapy of Lake Forest, LLC is dedicated to keeping your health records confidential. I acknowledge that I have been offered a copy of the HIPPA Notice of Privacy & Compliance document and understand the HIPAA Notice of Privacy & Compliance policies.

I authorize and consent to the use and disclosure of my protected health care information as outlined in the Physical Therapy of Lake Forest, LLC HIPPA Notice of Privacy & Compliance document.

If you have questions regarding your HIPAA Privacy rights and our Compliance Policies, please contact Toni Smith, our Patient Service Representative and Medical Office Receptionist by calling (847) 455-6674 or by emailing Toni at manager@ptlakeforest.com

Please note a more detailed HIPAA notice is available upon request.

____

Patient name (print)

____ _____________________

Signature of patient or responsible party Date

Name: ______________________________ DATE: ______________

MEDICAL SCREENING FORM

Circle YES or NO...

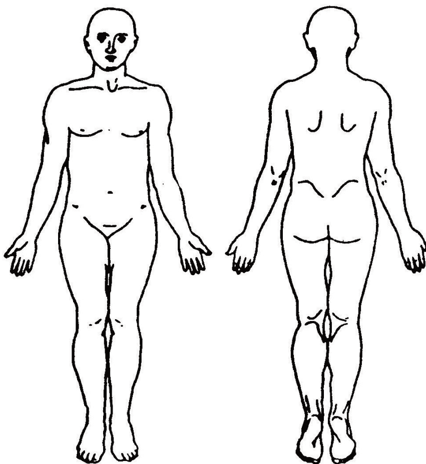
Have you or any immediate family member ever been told you have:

	Self		Family	
Cancer?	Yes	No	Yes	No
Diabetes?	Yes	No	Yes	No
High Blood Pressure?	Yes	No	Yes.	No
Heart Disease?	Yes	No	Yes	No
Angina/chest pain?	Yes	No	Yes	No
Stroke?	Yes	No	Yes	No
Osteoporosis?	Yes	No	Yes	No
Osteoarthritis?	Yes	No	Yes	No
Rheumatoid arthritis?	Yes	No	Yes	No

In the past 3 months have you had or do you experience:

A change in your health?	Yes	No
Nausea/vomiting?	Yes	No
Fever/chills/sweats?	Yes	No
Unexplained Weight Change?	Yes	No
Numbness or tingling?	Yes	No
Changes in appetite?	Yes	No
Difficulty swallowing?	Yes	No
Changes in bowel or bladder function?	Yes	No
Shortness of Breath?	Yes	No
Dizziness?	Yes	No
Upper respiratory infection?	Yes	No
Urinary tract infection?	Yes	No

Please use the diagram below to indicate where you feel symptoms right now.



Circle YES or NO...

Do you have a history of:

Allergies/ Asthma?	Yes	No
Headaches?	Yes	No
Bronchitis?	Yes	No
Kidney disease?	Yes	No
Rheumatic Fever?	Yes	No
Ulcers?	Yes	No
Sexually transmitted disease?	Yes	No
Seizures?	Yes	No

Are you currently:

Pregnant?	Yes	No
Depressed?	Yes	No
Under Stress?	Yes	No

Are your symptoms: (check one)

☐ Getting Worse ☐ The same ☐ Improving

How are you able to sleep at night? (check one)

☐ Fine ☐ Moderate Difficulty ☐ Only with medication

Check all that apply...

Do you have a problem with... (Check all that apply)

☐ Hearing ☐ Vision
☐ Speech. ☐ Communication

Do you or have you in the past smoked tobacco? YES NO

If yes,__________Packs X__________Years.

Last tobacco use__________

Do you drink alcoholic beverages? YES NO

If yes, how many drinks do you routinely have per week?

__________/week.

Date of last physical examination __________

List medications currently using: ______________________

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