

New Patient Registration Forms

Name:

Last First MI

Address:

Street City State Zip code

Cell Phone: _____ Work: _____ Home: _____

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? _____

What brings you in today? Is this a new or recurring problem? _____

Primary Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

Parent or Responsible Party (*if different than patient*) Name: _____

Address: _____ Relationship to Patient: _____

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 #: _____

Name: _____

Date: _____

MEDICAL SCREENING FORM

Please circle yes or no below

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

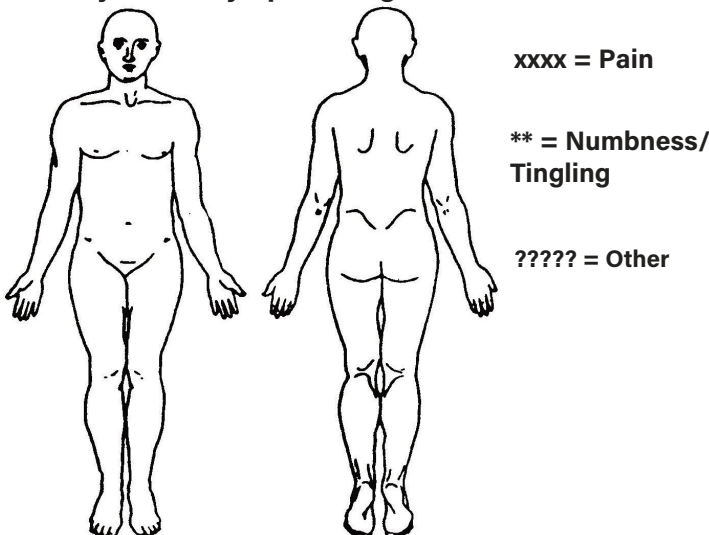
	<u>Self</u>		<u>Family</u>	
	Yes	No	Yes	No
Cancer?				
Diabetes?				
High Blood Pressure?				
Heart Disease?				
Angina/chest pain?				
Stroke?				
Osteoporosis?				
Osteoarthritis?				
Rheumatoid arthritis?				
Other? _____				

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

IMPORTANT:

Please DRAW on 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:	Yes	No
Pregnant?	Yes	No
Anxious or 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

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

- Hearing Vision
- Speech Communication

Do you (or have you) smoked tobacco? YES NO

If yes, #packs per week: _____ x # of years: _____

Date of last tobacco use: _____

Do you drink alcoholic beverages? YES NO

If yes, # of drinks do you usually have per week? _____

Date of last annual physical examination: _____

List medications currently using: _____

Have you had COVID-19? _____

If yes, when? _____ Are you vaccinated? _____

Name: _____

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

Signature of patient (or responsible party)

Date

Accepted Methods of Payment: Cash, Credit, Debit, FSA, HSA Cards, Checks.

There is a \$30.00 charge for any returned checks.

HIPAA Privacy Notice & Compliance

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

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 Stephanie Apaez, Office Manager by calling (847) 455-6674 or by emailing manager@ptlakeforest.com

Please note a more detailed HIPAA notice is available upon request. Additional information is posted in the waiting room.

Patient name (print)

Signature of patient or responsible party

Date