



PATIENT INTAKE PACKET

Name: _____ Date: _____

How did you hear about us?: _____

Occupation: _____ Currently working: yes no

Physician: _____ Date of next visit with physician: _____

Current Injury Information

1. Briefly describe your current problem, complaint or injury and how it occurred

2. What was the date you current problem, complaint, or injury began? _____

3. Please list previous treatment and/or tests you have received for this condition:

Treatment	Date	Benefit
_____	_____	_____
_____	_____	_____

Test (x-rays, CT scan, MRI, other)	Date	Benefit
_____	_____	_____
_____	_____	_____

4. Please list all medications you are currently taking: _____

5. What activities are you currently having difficulty with due to your injury?: _____

7. What goals do you wish to achieve in therapy?: _____

8. What were your activities prior to onset of problem?: _____

Basic Medical Information

1. Please check any of the following conditions which you have now or have had in the past:

allergies (please list)_____

- | | | |
|--|--|---|
| <input type="checkbox"/> anxiety | <input type="checkbox"/> fractures | <input type="checkbox"/> migraines |
| <input type="checkbox"/> asthma | <input type="checkbox"/> head injury | <input type="checkbox"/> multiple sclerosis |
| <input type="checkbox"/> bowel/bladder changes | <input type="checkbox"/> hearing loss | <input type="checkbox"/> neck/back pain |
| <input type="checkbox"/> cancer | <input type="checkbox"/> heart attack | <input type="checkbox"/> night sweats |
| <input type="checkbox"/> chemical dependency | <input type="checkbox"/> heart disease | <input type="checkbox"/> pace maker |
| <input type="checkbox"/> circulatory problems | <input type="checkbox"/> heart murmur | <input type="checkbox"/> rheumatic fever |
| <input type="checkbox"/> depression | <input type="checkbox"/> hepatitis | <input type="checkbox"/> shortness of breath |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> skin allergies |
| <input type="checkbox"/> DVT | <input type="checkbox"/> ITB | <input type="checkbox"/> stroke |
| <input type="checkbox"/> emphysema/bronchitis | <input type="checkbox"/> incontinence | <input type="checkbox"/> swallowing problems |
| <input type="checkbox"/> epilepsy/seizures | <input type="checkbox"/> kidney disease | <input type="checkbox"/> thyroid |
| <input type="checkbox"/> food intolerance | <input type="checkbox"/> lung disease | <input type="checkbox"/> varicose veins |
| <input type="checkbox"/> vision loss | <input type="checkbox"/> metal implant | <input type="checkbox"/> unexplained weight loss/gain |

2. List any other health problems:_____

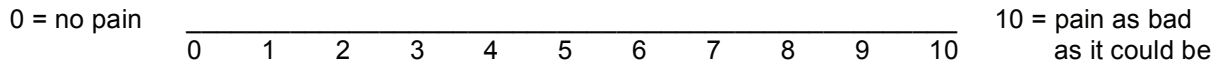
3. Please list any surgeries you have had:_____

4. Are you a smoker? _____ If yes, how many packs per day? _____

5. Are you pregnant or is there a chance you are pregnant? Yes No How many weeks?_____

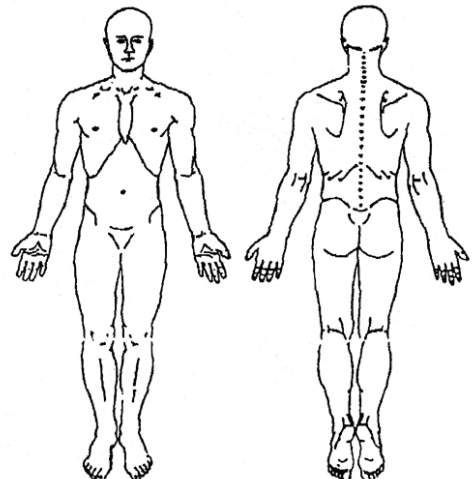
Pain Report

1. Please indicate your present pain level for primary injury:



2. Please mark on the diagram where you have pain or other symptoms:

3. Please describe your pain/symptoms below:



I have reviewed this information and integrated it into the patient's treatment program.

Therapist signature:_____ Date:_____

ELITE PHYSICAL THERAPY

FINANCIAL POLICY

Thank you for choosing us as your Physical Therapy Provider. We will strive to work closely with you, your physician and your other health care providers to provide you with the best possible care. Please review the following information regarding our financial policy. Please also understand that timely payment for your treatment is important and your full understanding of our financial policy is important to our professional relationship.

Our Financial Policy is:

- ∞ All co-pays are due at the time of service.
- ∞ Payment is due in full at the time of service unless other arrangements have been made.
- ∞ We accept cash, credit cards and checks

CANCELLATION POLICY

Failure to keep your scheduled appointments hinders our ability to provide the best possible care to all of our patients. We ask that you show us consideration by calling at least 24 hours prior to your appointment if you are unable to attend. This will allow us the opportunity to offer that appointment to another patient.

Our Cancellation Policy is:

- ∞ **Failure to give 24 hours notice prior to cancellation will result in a “No-Show Appointment Fee” of \$25.** This fee cannot be billed to your insurance company and will be your direct responsibility.
- ∞ Repeated late cancellations or no-shows are disruptive to the optimal delivery of care to you and our other patients. As a result, **3 late cancellations or no shows will result in discontinuing physical therapy.**

INSURANCE

Please be aware that your medical insurance is a contract between you and your insurance company. We are not party to this contract. Elite Physical Therapy will submit all claims for charges to your insurance provider as a service to you. Co-Pays must be paid at the time of service in order to abide by your insurance contract. If your policy requires a referral, failure to obtain and present this at the time of service may result in loss of benefits. If this occurs, you will be responsible to pay all fees. If you need assistance in obtaining a referral, please ask one of our billing staff.

I have read the above policies and agree to them. I authorize Elite Physical Therapy to provide me with Physical Therapy services and to furnish information to my insurance company, worker’s comp carrier or attorney concerning my injury and treatment. I understand that I am financially responsible for payment of all services not covered by my insurance company.

Signature of Patient/Guardian: _____ **Date:** _____

PATIENTS PLEASE READ AND SIGN

In order to submit claims on your behalf in a timely manner, we require you to sign a written statement allowing us to keep your signature on file. This authorizes Elite Physical Therapy to submit assigned and non-assigned claims on your behalf.

Name: _____ Insurance Claim Number: _____

“I request that payment of authorized Medicare and other insurance benefits be made either to me or on my behalf to the name of the provider of service and/or supplier for any services furnished to me by that provider of services and/or supplier. I authorize any holder of medical information about me to release to the centers for Medicare and Medicaid Services and/or my insurance carrier and its agents any information needed to determine these benefits or the benefits payable for related services.”

Signature of Patient/Guardian: _____ **Date:** _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have **RECEIVED / REFUSED** the notice of Privacy Practices from Elite Physical Therapy Ltd.

Signature of Patient/Guardian: _____ **Date:** _____



1455 South Michigan Ave., Suite 230, Chicago, IL 60605

Tel: (312) 360-0702 Fax: (312) 360-0705

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____

Date of Birth: _____

Social Security Number: _____

I, _____, hereby authorize you to release my protected healthcare information to Elite Physical Therapy (fax: 312.360.0705). This request applies to:

- Healthcare information related to the following condition(s): _____

- All healthcare information
- Other: _____

Patient Signature: _____ Date: _____

ELITE PHYSICAL THERAPY
Patient Information

Nombre: _____
Direccion: _____ **Unidad** _____
Ciudad: _____ **Estado:** _____ **Zona postal** _____
Telefono de Casa: _____ **Cellular:** _____
Email _____
Fecha de Nacimiento: _____ **Seguro Social #** _____
Empleador: _____ **Numero de Telefono:** _____

Physician: _____ **NPI#:** _____
phone: _____ **Fax #** _____
Primary insurance co _____ **HMO PPO POS MEDICARE**
Address: _____
Phone: _____ **Fax:** _____
Policy # _____ **Group #** _____
Insured's name: _____ **Insured's DOB:** _____
Effective Date of insurance: _____ **Insured's Relationship to Patient:** _____

.....OFFICE USE ONLY.....

INS Contact: _____ **Pre-Certification Required? #:** _____
Diagnosis: _____ **ICD9:** _____ **Effective Date:** _____
In Network: Deductible: \$ _____ **Co-pay: \$** _____ **Co-Insurance (%covered):** _____
Out of Network: Deductible: \$ _____ **Co-pay: \$** _____ **Co-Insurance (%covered):** _____
Visit Limit per Dx: _____ **Per Year** _____ **Fiscal Limit per Dx: \$** _____ **Per Year: \$** _____

W/C Claim # _____ **DOI:** _____ **Physician:** _____
Phone: _____ **Fax:** _____
Insurance Name: _____
Insurance address: _____
Phone _____ **Fax** _____
Claim Adjuster _____ **Phone:** _____ **Fax:** _____
Rehab Nurse; _____ **Phone:** _____ **Fax:** _____
Attorney: _____ **Phone:** _____ **Fax:** _____
Attorney Address: _____