GIVEN
SPORTS & PHYSICAL THERAPY
EXPERTISE • EXPERIENCE • PERSONAL ATTENTION

Featuring McHenry County's First Board Certified Clinical Specialist

Consent for Care & Treatment: I agree and give consent for medical care and treatment to _____ as considered medically necessary in evaluating and treating my/his/her physical condition.

Patient/Guardian/Responsible Party _____ Date: _____

Benefit Assignment/Release of Information: I agree to assign all medical benefits to which I am entitled to Given Sports & Physical Therapy, PC for services rendered. I hereby authorize release of all information necessary to secure payment for these services.

Patient/Guardian/Responsible Party _____ Date: _____

Financial Policy Explanation:

- Proper identification is needed at the time of the initial evaluation.
- Accurate insurance and injury information must be presented by the patient.
- If benefits are subsequently denied by an insurance company, the patient is fully responsible for the charge of rendered services.
- Although benefits and coverage are verified prior to therapy, the patient is fully responsible to understand their individual benefits and plan details. Pre-verification of benefits/coverage is only an estimate of coverage and not a guarantee of benefits.
- Patients under the age of 18 years old require signed consent from a parent/guardian.
- Patients should be aware that some insurance plans require specific pre-authorization or referral for physical therapy.
- If an insurance carrier does not remit payment within 120 days, the balance shall be considered patient responsibility at that time.
- Pre-collection notices may be sent after the same patient balance is billed on two consecutive occasions. Patients will be responsible for all costs of collecting monies including court costs, additional collection agency fees of 35%, and attorney fees incurred.
- A $25 charge will be assessed for any dishonored/returned check or any failed payment plan transaction.
- Medical supplies - payment is due in full at the time of receipt as these are not billed to any insurer; payment for medical goods is non-refundable

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Commercial Insurance:

- Co-payments: Without exception, insurance companies require that co-payments be paid at the time of service.
- Co-insurances and deductibles: Estimated co-insurance and deductible payments are due at the time of service. After an EOB is received from the insurance company, any remaining balance will be billed to the patient.
- Any refund due to the patient will be credited to an active account or a refund check will be issued once all insurance payments are received.

Medicare: Claims will be submitted to Medicare and any supplementary/secondary plan. Clients are urged to speak directly to the therapist about the implications of calendar year caps on Medicare services. Clients need to notify this office if any home health therapy or nursing services have just concluded or occur during the course of therapy.

Workers' Compensation: It is our obligation to notify case managers/adjusters of missed or cancelled appointments.

Auto/Personal Injury: The client may I) elect to self-pay for services or 2) elect that this office bills their personal health or auto insurance. Personal health insurance shall be considered a secondary payor to auto insurance. No 3rd party billing is allowed.

Self-pay: Payment is due at the time of service at the lesser of billed charges or $125 per treatment session.

Patient/Guardian/Responsible Party _____ Date: _____

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Patient Health Questionnaire

Name _____ Date: _____

Date of Birth _____ Patient Acct. # _____

Referring Physician: _____ Family Physician: _____

Date of 1st doctor visit for this injury/condition: _____

Are you aware of what your diagnosis is? (Yes or No) _____

What are your rehabilitation expectations or goals? _____

Have you had Surgery for this injury? _____

Have you had Surgery for this injury? Yes No _____

Type of Surgery: _____ Approx date(s) of surgery:_____

Your chief complaint:. _____

Date of onset of symptoms or Injury:_____

- How often do you experience your symptoms?
  - Constantly (76 -100% of the day)
  - Frequently (75% of the day)
  - Occasionally (26 - 50% of the day)
  - Intermittently (0 - 25% of the day)

- What describes the nature of your symptoms: (Choose all that apply)
  Sharp Dull ache Numb Shooting Tingling

- How are symptoms changing: Getting better Not changing Getting worse

- During the past 4 weeks:

a. Indicate the average intensity of your symptoms: None Unbearable

b. How much pain interfered with your normal work:
(including both work outside the home and housework)?

Not at all A little bit Moderately Quite a bit Extremely

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- During the past 4 weeks how much of the time has your condition interfered with your social activities? (visiting with friends, relatives, etc.)

All of the time Some of the time None of the time A little of the time Most of the time

- In general, would you say your overall health right now is:

Excellent Very good Good Poor

- Who have you seen for your symptoms? (Choose all that apply)

No One Physical Therapist Chiropractor Medical Doctor Occupational Therapist Orthopedist Other

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed

X-Rays MRI CT Scan Other

c.What medication are you currently taking for this injury?_____

- Have you had similar symptoms in the past? Yes or No _____

- If you have received treatment in the past for the same/similar symptoms, who did you see?

This Office Medical Doctor Occupational Therapist Chiropractor Physical Therapist Orthopedist Other

- What is your occupation? _____

- If you are not retired, a homemaker, or a student, what is your current status?

Full Time Part-time Self-employed Unemployed Off work Other

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Please circle Y (yes) or N (no) If you have, or have had condition. Circle M (medications) If you are taking medications for !he condition.

General			
Good general health	Y	N	M
Recent weight changes	Y	N	M
Fatigue	Y	N	M
Night sweats / fevers	Y	N	M
Cardiovascular			
Anglna / chest pain	Y	N	M
Coronary artery disease	Y	N	M
Heart surgery	Y	N	M
Pacemaker	Y	N	M
Musculoskeletal			
Muscle pains or cramps	Y	N	M
Stiffness I swelling in joints	Y	N	M
Joint Pain	Y	N	M
Osteoporosis	Y	N	M
Endocrine			
Excessive thirst/ urination	Y	N	M
Thyroid disease	Y	N	M
Hormone Problem(s)	Y	N	M
Ear/ Nose / Throat /Mouth			
Hearing loss I ringing in ears	Y	N	M
Sinus Problems	Y	N	M
Nose bleeds	Y	N	M
Sore throat	Y	N	M
Voice Changes	Y	N	M
Respiratory			
Shortness of Breath	Y	N	M
Excessive coughing	Y	N	M
Asthma			
Bronchitis	Y	N	M
Emphysema	Y	N	M
Neurologlcal			
Frequent headaches	Y	N	M
Seizures / Epilepsy	Y	N	M
Numbness I tingling	Y	N	M
Dizziness	Y	N	M
Weakness	Y	N	M
Stroke/TIA	Y	N	M
Hematologic / Lymphatic			
Bruise Easily	Y	N	M
Slow to Heal	Y	N	M
Enlarged Glands	Y	N	M
Eyes			
Wear glasses / contacts	Y	N	M
Blurred / double vision	Y	N	M
Eye Disease or injury	Y	N	M
Glaucoma	Y	N	M
Allergies			

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Food	Y	N	M
Latex	Y	N	M
Medicine	Y	N	M
Gastrointestinal			
Nausea/Vomiting	Y	N	M
Abdominal Pain	Y	N	M
Rectal Bleeding	Y	N	M
Blood In Urine	Y	N	M
Kidney Stones			
Other			
Skin Infection or MRSA	Y	N	M
Changes in hair or nails	Y	N	M
Rashes or itching	Y	N	M
Breast Lump	Y	N	M
Breast Pain or discharge	Y	N	M
Change in menstrual cycle	Y	N	M
Tuberculosis	Y	N	M
Cancer	Y	N	M
Radiation / Chemotherapy	Y	N	M

HIV / AIDS	Y	N	M
Diabetes	Y	N	M
Blood Clots	Y	N	M
Depression	Y	N	M
Confusion / Memory Loss	Y	N	M
Do you smoke?	Y	N	M
Use tobacco products?			
Are you pregnant?	Y	N	M

Patient/Guardian/Responsible Party _____ Date: _____

I have reviewed and discussed this patient medical information with the patient

Therapist _____ Date: _____

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We are committed to providing quality healthcare services to you. An important part of that is facilitating various privacy tights that you have under Federal Law.

This document serves 2 purposes:

1. Acknowledgment by signature that the Notice of Privacy Practices has been made available for review. Signature Indicates understanding and agreement with said Notice.
2. 2.Instructions to request any restriction pertaining to the uses and disclosures of your protected health information ("PHI-) that we may make for treatment, payment and operational reasons, as well as for other reasons provided for under applicable law.

Notice of Privacy Practices:

I understand the Notice of Privacy Practices (posted at www.givensportsptcom and available for review in the clinic Itself) and consent to disclosure for permitted uses. I fully understand the terms of consent.

Patient Name _____ Date of Birth: _____

Patient/Legal Representative Signature: _____ Date: _____

Restriction Request:

Describe the PHI that you would like restricted including any individual(s), provider(s), Insurance company(s) and/or other organization(s) that you would like to prevent from reviewing the designated PHI.

Detailed Description of restricted information: _____

Persons or Organizations Restricted: _____

It Is our policy to process restriction requests within thirty days (30) of receipt. We will use the contact Info that we have on file to: 1) follow-up with you for additional information If necessary; and/or 2) send you our written response to your request.

Patient Name _____ Date of Birth: _____

Patient/Legal Representative Signature: _____ Date: _____

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Authorization:

Given Sports & Physical Therapy may release Information regarding my treatment to the following Individuals:

Name _____ Relationship: _____

Name _____ Relationship: _____

Patient Name _____ Date of Birth: _____

Patient/Legal Representative Signature: _____ Date: _____

Sports Medicine • Orthopedics • Spine Rehab • Balance Training • Functional Capacity Evaluations • Work Conditioning

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