BodyGears Physical Therapy

CHICAGO/RIVER NORTH
CHICAGO/LINCOLN PARK
OAK BROOK
OAK PARK
WHEATON
WINNETKA

www.BodyGears.com 877-709-1090

PATIENT REGISTRATION FORM

Last Name:	First Name:		Middle:	
Address:	City:		State:	Zip:
* Social Security Number:	DOB: (mm/dd/yyyy)	Age:	Sex: ❍ M ❍ F	Marital Status: ❍ S ❍ M ❍ W ❍ D
Home Phone:	Cell Phone:		Work Phone:	
e-Mail Address:	Preferred Method of Contact: ❍ Home ❍ Work ❍ Cell ❍ E-Mail			
Reason for Appointment:			Which Side of the Body? ❍ Left ❍ Right	Date Symptoms Began:

PHYSICIAN INFORMATION

Signing Physician:	Signing Physician Phone:		
Address:	City:	State:	Zip:
* Primary Care Physician:	* Primary Care Physician Phone:		
* Address:	* City:	* State:	* Zip:

HOW DID YOU FIND OUT ABOUT BODY GEARS PHYSICAL THERAPY?

❍ I am a Former Patient
❍ Website: _____
❍ Insurance Co. Recommendation
❍ Google
❍ Clinic Sign
❍ Family/Friend Recommendation
Name _____
❍ Workers' Comp./Case Manager
❍ Yelp
❍ Doctor Recommendation
❍ Other: _____

Photo ID, insurance card, and co-pay are required on day of visit. If you did not bring insurance cards with you, all charges will be your responsibility and payable at time of service. Obtaining required referral forms and treatment precertification is the patient's responsibility. ALL UNPAID BALANCES AND/OR DENIED CLAIMS ARE YOUR RESPONSIBILITY.

Patient/Parent or Guardian Signature:	Date:

Fields marked with an (*) are optional.


PRINT

FILL OUT

FAX to **630-876-9187**
& bring to your appointment.

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* WORKERS' COMPENSATION INFORMATION			
Work-related Injury? ❍ Yes ❍ No		Date of Accident: (mm/dd/yyyy)	
Name of Workers' Compensation Carrier:		Claim Number:	
What part of the body was injured?			
Address:	City:	State:	Zip:
Phone Number:		Last Date Worked?	
Adjuster's Name:		Phone Number:	

* ACCIDENT INFORMATION			
Motor Vehicle/Personal Related Injury? ❍Yes ❍No		Accident Date:	
Motor Vehicle Compensation Carrier:		Claim Number:	
Address:	City:	State:	Zip:
Phone Number:	Last Work Date:	State Accident Occurred:	

* ATTORNEY INFORMATION			
Attorney's Name (if lawsuit is involved):		Phone Number:	
Address:	City:	State:	Zip:

I, the undersigned, hereby certify that have answer the questions listed above accurately and to the best of my knowledge.

Patient/ Parent or Guardian Signature:	Date:

Fields marked with an (*) are optional.


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FINANCIAL POLICY

ALL PAYMENTS ARE EXPECTED AT THE TIME OF SERVICE **Initials** _____ *(for the information below)*

Please note, all Patient Responsibility Payments are due at time of service unless other arrangement were made prior to initial appointment. This includes all deductible, co-insurance, and co-payment amounts.

Also, please note that payments made at time of service are for an **estimated** amount based on benefit information provided by your insurance company, and **not the exact** amount you will owe for any given date of service. Final dollar amount due for services will be **determined after** your insurance processes your claim.

The clinic accepts cash, personal checks (in-state only), VISA, MasterCard, American Express, and Discover. There is a $25.00 service charge for returned checks. All patients are required to supply the clinic with a valid credit or debit card prior to their first visit to ensure timely payment of insurance non-payment and owed amounts.

Patients with an outstanding balance 60 days or older authorize the clinic to charge their credit or debit card on file for the balance due. If we are unable to collect payment from your debit or credit card on file we may forward your account to a third party collection agency. Please note we will not book any additional appointments until your balance has been paid in full.

INSURANCE **Initials** _____ *(for the information below)*

Our office will check your benefits as a courtesy to you and provide this information on or before your first appointment. The benefit information we will provide for you is only a quote of benefits, so it is not a guarantee that we will receive payment from your insurance company for services rendered. The actual benefit for services provided will be determined by your insurance once they receive your claim.

We bill participating insurance companies as a courtesy to you. You are expected to pay your deductible, co-insurance, and/or co-payment at the time of service. If we have not received payment from your insurance company within 60 days of the date of service, you may be expected to pay the balance in full. Please note, even though we will bill your insurance carrier, you are still responsible for payment of all services rendered whether by you or your insurance company.
We do not bill secondary insurance companies. However, we will provide any and all necessary receipts for you to be able to submit your claim to your secondary insurance.

REFUNDS **Initials** _____ *(for the information below)*

Patient/guarantor credits in amounts less than $20.00 will be retained on account to be credited toward future balances unless a written request for refund is received. Amounts $20.00 and greater will automatically be refunded to the patient/guarantor.

MISSED APPOINTMENTS/LATE CANCELLATIONS **Initials** _____ *(for the information below)*

Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. A $25.00 cancellation fee will be assessed for any appointments cancelled with less than 24 hour notice. Excessive abuse (more than 3 cancellations in a 12 month period) of scheduled appointments may result in discharge from the practice and/or $75.00 fee.

I have read and understand the Clinic's Financial Policy. I agree to assign insurance benefits to the Clinic's Practice whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I may also be responsible for the fee charged by the collection agency for cost of collections.

Signature _____ Date _____


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PATIENT MEDICAL HISTORY

Name: _____

Diagnosis/What body part(s) you are being referred for:

_____

Dates Symptoms Began: _____

Please Check: ❍ Work Injury ❍ Motor Vehicle Accident
❍ Other _____

Did this injury require surgery? ❍ Yes ❍ No

Kind of surgery and Date: _____

What medications are you taking for your current injury (if any)?

_____

_____

Please list all Medications:

_____

_____

Mark on the scale below your pre-injury level of function:
❍ 0% ❍ 10% ❍ 20% ❍ 30% ❍ 40% ❍ 50%
❍ 60% ❍ 70% ❍ 80% ❍ 90% ❍ 100%

Mark on the scale below your present level of function:
❍ 0% ❍ 10% ❍ 20% ❍ 30% ❍ 40% ❍ 50%
❍ 60% ❍ 70% ❍ 80% ❍ 90% ❍ 100%

Please describe the location of your pain:

_____

Please indicate which of these words, if any, describe your pain. Check all that apply.
❍ Aching ❍ Numb ❍ Shooting ❍ Tingling
❍ Burning ❍ Sharp ❍ Throbbing

Rate your pain intensity on a scale of 0-10. (0 being no pain)
Current pain _____ /10
At best _____ /10
At worst _____ /10

Which activities increase your symptoms? Check all that apply.
❍ Bending ❍ Reaching ❍ Squatting ❍ Walking
❍ Driving ❍ Reclining ❍ Stairs
❍ Kneeling ❍ Rising ❍ Standing
❍ Lifting ❍ Sitting ❍ Twisting
❍ Other _____

What eases your symptoms?
❍ Moist Heat ❍ Ice Application ❍ Medication
❍ Rest ❍ Change in position
❍ Other _____

Normal Physical Work Activities:

_____

_____

Is your condition overall:
❍ Improving ❍ Getting Worse ❍ Staying the same

Have you had any treatment of this current problem in the past?
❍ Yes ❍ No

Have you received any of the following tests for this problem?
❍ X-rays ❍ CT Scan ❍ Bone Scan
❍ EMG ❍ Nerve Conduction Study ❍ MRI
❍ Other _____

Medical History Information: If you have/had any of the following conditions, please check and give approximate dates or indicate current. If it does not apply, please write N/A.

❍ Arthritis _____
❍ Asthma _____
❍ Blood Pressure Problems _____
❍ Broken Bones _____
❍ Convulsions _____
❍ Diabetes _____
❍ Disabling Headaches _____
❍ Disc Trouble _____
❍ Fainting Spells _____
❍ Heart Problems _____
❍ Osteoporosis _____
❍ Pacemaker Implantation _____
❍ Paralysis or Muscle Weakness _____
❍ Pregnancy _____
❍ Spine Issues _____
❍ Tumor or Cancer _____
❍ Other _____

Please list ALL previous surgeries and the year performed regardless of body part:

_____

_____

_____


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CONSENT FOR TREATMENT

I, the undersigned, do hereby agree and give my consent for Body Gears Physical Therapy to furnish medical care and treatment to myself or _____, considered necessary and proper in diagnosing or treating my physical condition.

Patient/Guardian Signature _____ Date _____

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I, the undersigned, hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third party payers to Body Gears Physical Therapy.
A photocopy of this assignments to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records, to secure payment.

Patient/Guardian Signature _____ Date _____

CANCELLATION POLICY

Together, you and your therapist will set your treatment goals and time frames to complete these goals. It is important that you attend all scheduled treatment sessions to achieve the best success. If you must cancel or change an appointment, we request that you give us 24-hour notice prior to your scheduled appointment time by calling 877-709-1090. There will be a $25.00 cancellation fee that is not reimbursable by your insurance company if we are not given 24-hour notice. After three cancellations or no-shows, we reserve the right to charge $75.00 per cancellation or no-show, per scheduled appointment. If you are a worker's compensation patient, please be advised that your employer, physician, and rehabilitation nurse/adjustor may be notified of each missed appointment.

I acknowledge that I have read and understand this cancellation policy.

Patient/Guardian Signature _____ Date _____


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MEDICAL RECORD PRIVACY INFORMATION

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our Policy on Medical Record Privacy
This notice will describe the way our practice will treat medical records we keep regarding your medical care. We are required to keep a record for you care, including your diagnosis, treat- ment, services you receive, and other information. We are re- quired by law to protect your personal medical record by keep- ing it private and following certain rules that dictate whether and when we can use or disclose your information. This notice will inform you of these rules. It will also notify you of your rights and our obligations in our use and disclosure of your health in- formation. We are also required to give you notice, and to fol- low the terms of the notice that is currently in effect. We reserve the right to change this notice, and apply those changes to health information we currently have, as well as information we may receive in the future. If we change this notice, you will re- ceive a new copy of this notice the next time you receive ser- vices from our practice. A copy of this notice the next time you receive services from our practice. A copy of this notice will be on display in our office.

Understanding Your Health Record
Each time you visit Body Gears Physical Therapy, a record of your visit is made. Typically, this record contains your symptoms, examination, test results, diagnosis, treatment, and a plan for future care of treatment. This information, often referred to as your health or medical record, may serve as a:
• Basis for planning you care and treatment
• Means of communication among the many health professionals who contribute to your care
• Legal document describing the care you received
• Means by which you or a third party payer (such as your insurance company or HMO) can verify that services billed were actually provided
• A source of data for medical research
• A source of information for public health officials charged with improving the health of Illinois and the nation
• A source of data for planning and marketing
• A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Your Rights Regarding Your Health Information
You have the right to:
• Request that we restrict the use or disclosure of your health information for treatment, payment, or healthcare operations (as described in this notice)
• Request that we restrict from disclosing information to family or friends
• Request how you would like us to communicate with you
• Inspect and copy certain health information, including most of your medical and billing records. This request must be made in writing to the Privacy Officer. A reasonable fee may be applied for copying, postage, or other expenses related to your request. We may deny your request to inspect and or copy your health information. If we do, another licensed health care professional will review your request and we will comply with the outcome of the review.
• Amend your health record as provided in 45 CFR 164,528
• Obtain an accounting of disclosure of your health information as provided in 45 CFR 164,528
• Obtain a paper copy of this notice upon request
NOTE:
We are not required to agree to your requests. To request restrictions or limitations, you must make a written request to the Privacy Officer. The request must tell us (1) what information you want to limit; (2) whether you want to limit the use of the informa- tion and or disclosure of the information; (3) to whom the limitation or restrictions will apply.

Our Responsibilities
Body Gears Physical Therapy is required to:
• Maintain the privacy of your health information
• Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
• Abide by the terms of this notice
• Notify you if we were unable to agree to a requested restriction
• Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

For More Information or to Report a Problem
If you have questions and would like additional information, you may contact the practice's Privacy Officer at 877-709-1090.
If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the Office of Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office of Civil Rights.
The address for the OCR is listed below:

Office of Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

How We May Use and Disclose Your Health Information
We may use and disclose your health information for a number of purposes in connection with your medical care and in running our practice. The following lists a number of typical uses and disclosure within our practice. We will use your health informa- tion for the following:


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Treatment
We may use your health information to diagnose your illness or injury, provide you with services, or refer you to another physician. We may disclose your health information to doctors, nurses, technicians, medical students, or other personnel who are involved with your care. We also may disclose your health information to people outside of our medical practice who may be involved in medical care, such as family members, clergy or others.

Payment
We may give your health plan information regarding your diagnosis and treatment in order to be paid for your office visits, procedures, x-rays, or laboratory work. We may also provide information to determine whether your health plan pays for medical care you need, and whether we need to get authorization from the health plan before treating you.

Health Care Operations
We may use or disclose your information if we conduct quality assessment and improvement activities to ensure that our patients receive quality medical care. We may also use or disclose your information in training and evaluation of our physicians and other staff, or as part of a medical review, audit, or legal activities.

Appointment Reminders
We may use or disclose your information to contact you as a reminder that you have an appointment with our practice.

Individuals Involved in Your Care or Payment for Your Care
We may disclose your health information to a family member or friend who is involved in your medical care or who helps pay for your care. We may also tell your family or friends about your condition, for example, if you are admitted to the hospital or in the event of a disaster relief effort.

Public Health Risk
We may disclose your health information to report disease, injury or disability ; births and deaths; child abuse or neglect ; defects, recalls or problems with drugs, medical devices, or other products; to prevent or conditions. We may also notify authorities if we believe you have been the victim of abuse, neglect or domestic violence, if we are required by law to do so, or if you agree to the notification.

Health Oversight Activities
We may also disclose your health information to agencies authorized by law for audits, investigations, inspections, and licensure.

Law Enforcement
We may disclose your health information when the following circumstances apply:
• If you have incurred certain injuries or wounds that are legally required to be reported;
• In response to a court order, subpoena, warrant, summons, Investigative demands, or similar process;
• To identify or locate a suspect, fugitive, material witness, or missing person;
• About the victim of a crime if under certain limited circumstances;
• About a suspicious death that we believe may be the result of criminal conduct;
• About criminal conduct on our premises;
• In emergency circumstances to report a crime, its location, or information about the person who may have committed the crime.
Coroners, Medical Examiners, and Funeral Directors As necessary to carry out their duties.

Specialized Government Functions
We may disclose your health information to release information to military command authorities, upon you separation or discharge from military service to authorized officials. We may also disclose your health information to the appropriate government officials when it is necessary to conduct intelligence or other national security activities authorized by federal law. In addition, we may release your health information if it relates to the protection of the Presidents of the United States or foreign heads of state. Finally, we may disclose certain information related to members of the armed services and foreign military services to the appropriate personnel.

Inmates
If you are an inmate of a correctional facility or under the custody of a law enforcement official, we may disclose your health information to the correctional institution or law enforcement official in order to provide you with medical services, protect you or others, or to ensure safety of the correctional facility.

Workers' Compensation for Work Related Illness or Injuries
We may disclose your health information in relation to workers' compensation or similar programs established by law that provides benefits for work-related illness or injuries.

Other Uses of Your Health Information
We may disclose your health information when required by federal, state or local law, for treatment alternatives or health related benefits/services, organ and tissue donations, or to avert a serious threat to health or safety.

Contact Information
April Oury
910 West Van Buren St. Suite 419
Chicago, IL 60607
Mail: April@BodyGears.com
Phone: 877-709-1090
Fax: 630-876-9187

ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I received the Notice of Privacy Practices of Body Gears Physical Therapy.

_____ _____
Patient / Parent or Guardian Signature Date

_____
Patient / Parent or Guardian Printed Name

Office Use Only:

_____ _____
Witness Date


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CREDIT CARD AUTHORIZATION FORM

I, _____ , hereby authorize Body Gears Physical Therapy to charge my credit/debit/HSA card for the portion of the services that are my responsibility. This includes any patient responsibility from services rendered (deductibles, co-payments, and co-insurances) and/or fees incurred (cancellations within 24 hours or no-show appointments). I understand my card will be charged on a weekly basis for services received the previous week. I also understand that in the event my card declines, I will be required to provide a different method of payment. I will also be expected to pay for any previously unpaid charges resulting from the decline, in addition to the current charges due.

I authorize my card to be charged for:

_____ patient responsibility and fees incurred.

_____ fees incurred only.

Credit Card Number: _____

Exp. Date: _____ CVV code _____

Billing Address for the Debit/Credit Card listed above:

_____

_____

Patient Name: _____ Date: _____

Patient / Parent or Guardian Signature: _____


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