Healing Tree Physical Therapy Wellness
1100 Central Avenue, Suite G | Wilmette, Illinois 60091
Phone: (847) 512-4070 | Fax: (847) 512-4345

PATIENT INFORMATION

First Name:	Last Name:	Middle Initial:	Date: / /
Address:	City:	State:	Zip:
Birth date: / /	Age:	Male ☐ Female ☐	Home Phone: ( ) -
Work Phone: ( ) -	Cell Phone: ( ) -		
Email Address:	Fax #: ( ) -		

CARE PROVIDER INFORMATION

Referring Doctor:	Office Phone: ( ) -
Primary Care Physician:	Office Phone: ( ) -

INSURANCE INFORMATION

Primary Insurance Name:	
Subscriber's Name:	Birth date: / /
ID. #:	Group/Policy #:
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:_____	
Secondary Insurance Name:	
Subscriber's Name:	Birth date: / /
ID. #:	Group/Policy #:
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:_____	

HOW DID YOU HEAR ABOUT US?

Referred by: ☐ Dr. _____ ☐ Family ☐ Friend ☐ Insurance Plan

Saw Us In: ☐ Website:_____ ☐ Yellow Pages ☐ Yahoo Local ☐ Yelp ☐ Yellow Book
☐ Citysearch ☐ Superpages ☐ Topix ☐ Yippie ☐ Outside Sign ☐ Mail

☐ Other:_____

IN CASE OF AN EMERGENCY (please provide a local contact)

Name:	Relationship to Patient:
Home Phone: ( ) -	Work Phone (optional): ( ) -
Cell Phone (optional): ( ) -	

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Release of Information / Financial Policy

The following is a statement that we require you to read and sign prior to any treatment.

1. Scheduling

a. Missed Appointments Initials _____

Our goal is to provide quality care in a timely manner. In order to do so we have had to implement an appointment/cancellation policy. The policy enables us to better utilize available appointments for our patients in need of physical therapy care. Please help us serve you better by keeping your appointments. We recognize that, at times, it is not possible to keep appointments. If you are unable to keep an appointment, please call our office at least 24 hours prior to the appointment time. **We reserve the right and will charge your account a fee of $100 for missed appointments or cancelling your appointments with less than 24 hours notice.**

2. Treatment and Confidentiality Disclosures

a. Patient Privacy and Confidentiality Initials _____

The Healthcare Insurance Portability & Accountability Act (HIPAA) provides for patient privacy and confidentiality. By signing this agreement, I acknowledge receipt of information pertaining to my rights as covered under HIPAA. *Complete policy is available for review upon request.*

b. Release of Information Initials _____

By signing this form, you authorize the above designated clinic to release and disclose such medical records, information and documentation as necessary or appropriate in order to process insurance claims and to obtain payment on your behalf. You agree that a photocopy of your original authorization shall be considered equally authentic.

c. Usual and Customary Rates Initials _____

Our practice is committed to providing the finest in specialized physical therapy. Our main goal is to help restore function, improve mobility, relieve pain and prevent further injury through patient and family education. Given our mission, we routinely evaluate our fees to ensure they are consistent with other providers in our area.

3. Insurance Reimbursement Policies

a. Regarding Insurance Initials _____

As required by your insurance, payment of co-pays is required at the time of service. We cannot guarantee payment by your insurance; however, we do attempt to obtain information about your therapy benefit coverage upon arrival at our office. If you have any concerns about your insurance coverage, contact your insurance directly. Under the Healthcare Insurance Portability Accountability Act (HIPAA), we are not allowed to discount or waive patient's copays, deductibles or coinsurance amounts as outlined by insurance policies. As a courtesy to all our patients, we file insurance claims directly with your insurance company if you have provided us the information prior to services being provided. Since your insurance policy is a contract between you and your insurance company, all charges are ultimately your responsibility. We ask that you please make payments in full when you receive a statement. If you are unable to pay in full, please set up a payment arrangement with our office. **All balances must be paid in full or per payment arrangement upon receipt of your monthly statement in order to avoid a 10% late payment fee.**

b. Assignment of Benefits Initials _____

By signing this form, you authorize assignment of your benefits for treatment and related services to the above designated clinic. This means that your insurance will pay us directly.

c. Unmet Deductible Insurance Plans Initials _____

If upon insurance verification, you have an unmet deductible, be aware that all allowable charges are your responsibility. We will submit all charges to your insurance company in order for services to be applied to your deductible. Once we receive the EOB (Explanation of Benefits) indicating the amount has been applied to your deductible, we will send you a statement and expect payment to be made in full upon receipt. **For unmet deductibles please see our "Billing Procedure" form for further requirements and payment options. (*We provide two payment options on the "Billing Procedure" form)***

d. Durable Medical Equipment/Supply Type Items Initials _____

Often insurance companies do not cover the cost of items such as electrodes for the use of Electro-stimulation procedure, shoe inserts, braces, etc; therefore, the patient becomes responsible for these items. If you are concerned about insurance coverage of these types of items, please contact your insurance company. You may submit such items to your insurance on your own for reimbursement.

4. Legal Issues

a. Cases Involving an Attorney **Initials _____**

If you are receiving services that are related to an auto accident, worker's compensation claim or personal injury and you are working with an attorney, we expect a minimum monthly payment of $250 due upon receipt of a patient statement. In the case of an auto accident or personal injury case, we also require a copy of your health insurance card. This procedure is necessary in order to avoid timely filing issues with the health insurance in case the auto/personal injury carrier does not pay or is exhausted at some point prior to final payment. This procedure protects both you as the patient and us a provider from potentially large balances.

b. Bad Debt **Initials _____**

We cannot book any type of appointment for you if your account has a bad debt write-off or a large unpaid balance. You must pay in full any amounts due on your account prior to booking any appointments. Payment accepted will either in the form of Cash, Credit Card, Money Order or Cashier's Check; personal checks will not be accepted.

5. Payments and Fees

(see also "Missed Appointments" fee information)

a. Late Payment on Account Fee **Initials _____**

All Patient Balances are due upon receipt of monthly statement. Balances not paid by the following billing cycle or under a payment plan are subject to a **10% late fee**, which will accrue monthly until the account is current.

b. Past Due Accounts **Initials _____**

Any patient with a Past Due account may be denied a future appointment until balance is paid in full or a payment arrangement is made.

c. Returned Check Fee **Initials _____**

In the event that your personal check is returned unpaid by your bank, we require a $30 additional fee for each check. You must pay the balance owed, plus the Returned Check Fee by either Cash or Credit Card; a personal check will not be accepted.

By signing this form, I consent to receive treatment as prescribed by my physician and a qualified licensed therapist of the above designated clinic. I have read and understand the above statements concerning the clinic's expectations and my rights and obligations.

_____ _____

Signature of Patient or Responsible Party | Relationship to Patient if Responsible Party

_____ _____

Print name signed above | Date

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Billing Procedure for All Account Balances
(Including Unmet Deductibles)

All account balances are your responsibility - regardless of your insurance policy. A balance may accrue based on unmet deductibles, the percentage the policy holder is responsible for, or fees that have been applied such as missed appointments or late payment fees*. Statements are mailed out monthly and we allow two weeks to receive payment. If no payment is received **we will charge your credit card the amount of your balance.** Any patient with a Past Due account may be denied a future appointment until balance is paid in full or a payment arrangement is made.
*Refer to "Payments and Fees" section

If you have an **Unmet Deductible Plan**, be aware that all allowable charges are **your** responsibility. We will submit all charges to your insurance company in order for services to be applied to your deductible. Once we receive the EOB (Explanation of Benefits) indicating the amount has been applied to your deductible, we will send you a statement and expect payment to be made in full upon receipt.

In order for balances to be paid in full in a timely manner, and to keep your account in good standing we have two options for you to choose from. Be aware that Option #2 only applies for those with unmet deductibles.

Please choose which Option you plan to use:

☐ **Option #1**

We ask you for your credit card information. We accept VISA, MASTERCARD or DISCOVER. We will only store this information as long as you are an active patient with us. This sensitive material will be destroyed upon being discharged from Healing Tree Physical Therapy & Wellness. After we receive notice from your insurance company that the charges have been applied, we will send you a statement for the balance, and allow **two** weeks to receive your payment. If we do not receive your payment within two weeks, we will charge your credit card the balance due. **We will notify you that your credit card has been charged by sending you a receipt.**

☐ **Option #2 (only for Unmet Deductible Plans)**

If credit card information is not obtained, we will require a fee of $150.00 to be paid at the time of service **before** each treatment. This fee will be applied towards your balance and you will be billed for any remaining balance owed until you reach your deductible. Keep in mind that if that any account balance not paid by next billing cycle will incur a 10% late fee.

NOTE: Your Insurance Policy is an agreement between you and your insurance company; we simply submit claims on your behalf. Any fees not covered by your insurance company or that have been applied to your deductible are ultimately your responsibility.

Patient's Name (Printed): _____Date: _____

Signature of Responsible Party or Credit Card Holder: _____

☐ VISA ☐ MASTERCARD ☐ DISCOVER Card #_____

Exp. Date: _____ 3-Digit Security Code (on back of card): _____

HEALING TREE PHYSICAL THERAPY & WELLNESS

PATIENT MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____

Current Medical Issues

Describe injury or events leading to onset of symptoms/pain: _____

_____

Please indicate on a scale 0 - 10 your pain levels: (0 = Pain Free 10 = Worst) Least _____ Worst _____ Current _____

Describe your pain (i.e. sharp, ache, dull, etc.)_____

What activities increase/alleviate pain? (i.e. lying down, use of heat, etc.)_____

Are you taking any medications for this condition? (If yes, please name all that apply) ☐ Yes ☐ No

_____

What other medications are you currently taking and for what conditions? _____

_____

Have any of the following been performed for this condition?

☐ X-Ray List Body Part_____ Date_____
☐ CT Scan List Body Part_____ Date_____
☐ MRI List Body Part_____ Date_____

Is there any numbness or tingling? ☐ Yes ☐ No Where? _____
Do symptoms radiate to other body parts? ☐ Yes ☐ No Where? _____
Do you have trouble sleeping? ☐ Yes ☐ No
How often to you awaken at night due to pain? _____
Describe any other sleeping complication: _____

Are you pregnant? ☐ Yes ☐ No How many weeks? _____

Have you had Physical Therapy before? ☐ Yes ☐ No Where: _____

Past Medical History

Have you had, or do you currently have, problems with any of the following?

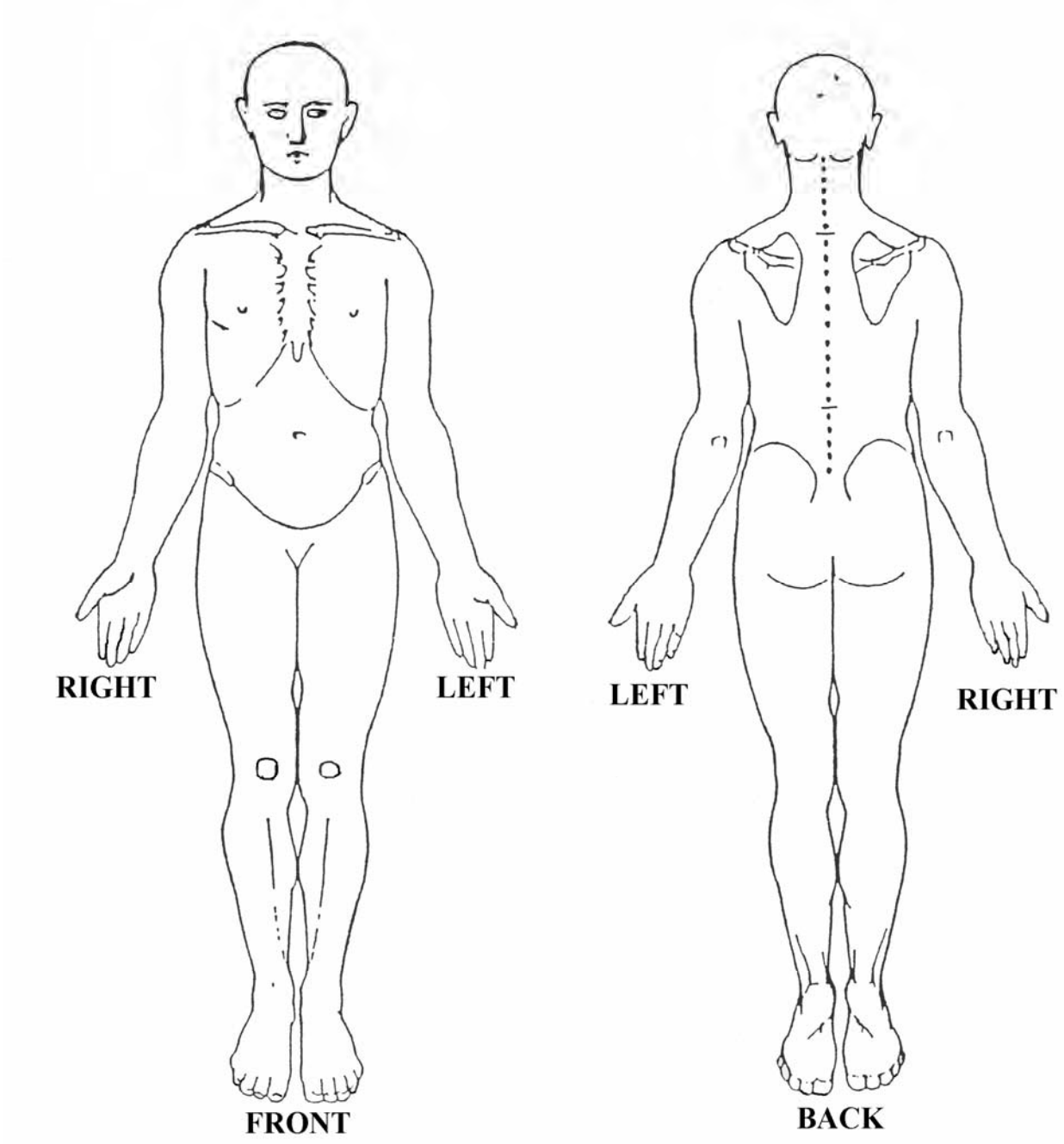
Heart Attack	Yes / No	Allergies	Yes / No	Heart Disease	Yes / No
High Blood Pressure	Yes / No	Hernia	Yes / No	Cancer	Yes / No
Dizziness	Yes / No	Diabetes	Yes / No	Stroke	Yes / No
Infections	Yes / No	Fibromyalgia	Yes / No	Bowel/Bladder	Yes / No
Metal Implants	Yes / No	Arthritis	Yes / No	Pacemaker	Yes / No
Epilepsy	Yes / No	Headaches	Yes / No	Defibrillator	Yes / No
Neurological Disorders	Yes / No	Asthma/COPD	Yes / No	Previous Surgery	Yes / No

Other _____

Patient Signature_____ Date _____

Use the key below to mark the areas of the body where you are having problems:

Pain Key:
OOOO Pins and needles
XXXX Burning
//////// Stabbing
==== Dull Ache
PPPP Other – describe _____



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Acknowledgement of Notice of Privacy Practices and Contact Authorization

Patient Name (please print): _____ **Date of Birth**:_____

The **Notice of Privacy Practice (NPP)** explains how we may use and share your health records. The NPP also describes your rights as a patient with respect to your health records. **Please read the attached summary of the Notice of Privacy Practice.**

- As required by law, we will use your records for treatment and billing purposes

I understand that the full version of the NPP is available on the **Healing Tree Physical Therapy & Wellness** website at, **www.healingtreept.com**, and at the office upon request. **I acknowledge receipt of the Notice of Privacy Practices (NPP).**

Signature of Patient (or Responsible Party)**:** _____ **Date:** _____

Print Name (if Responsible Party): _____ **Relationship to Patient:** _____

OFFICE USE ONLY

Office Signature: _____ **Title:** _____ **Date:** _____

Contact Authorization: Please CHECK all the ways we may contact you

Do the therapists, staff and billing company of **Healing Tree Physical Therapy & Wellness** have permission to contact you the following ways in regards to financial and/or medical information, including appointments?

Home: Yes ___ No ___ **Work:** Yes ___ No ___ **Cell Phone:** Yes ___ No ___

May we leave a **Message/Voicemail***? Yes ___ No ___
*If "No" is checked, the date and time of your appointment(s) may be left via answering machine/voicemail but no financial or medical information will be included

I give authorization to the therapists, staff and billing company of **Healing Tree Physical Therapy & Wellness** to discuss my financial and/or medical information (including appointments) with the following individual(s):

	Name	Relationship to Patient	Phone Number
(1)	_____	_____	_____
(2)	_____	_____	_____
(3)	_____	_____	_____

I understand that it is my responsibility to inform Healing Tree Physical Therapy & Wellness of any desired changes in this authorization. **Note: This authorization expires one year after the date of signature.**

Signature: _____ **Date:** _____