COVID-19 Questionnaire Agreement

To deliver a healthy treatment experience at Healing Tree Physical Therapy & Wellness, for our patients and clinicians alike, we are placing increased emphasis on following the CDC guidelines, including frequent and thorough hand washing/sanitizing throughout the day. All therapists and patients are required to wear masks. We are also sterilizing and disinfecting all clinic surfaces, as well as, screening all patients. We will be waiving our cancellation policy for those who are sick.

Have You Been Fully Vaccinated? ____YES ____NO

In general, people are considered fully vaccinated:

- 2 weeks after their second dose in a 2-dose series, such as the Pfizer or Moderna vaccines, or
- 2 weeks after a single-dose vaccine, such as Johnson & Johnson's Janssen vaccine

You must agree to wear a mask while being treated. _____ Initial

Are you currently or have you recently experienced any of the following symptoms: fever, cough, congestion, sore throat, runny nose, shortness of breath, change of smell or taste, muscle aches with flu-like symptoms, loss of appetite, chills or shaking chills, headache, diarrhea, nausea or other gastrointestinal symptoms?

____YES ____NO

Have you traveled anywhere in the past 14 days that has a level 3 travel warning (per the CDC)?

____YES ____NO

Had contact with a person under investigation (someone who has been tested for COVID-19 and is awaiting results) or has had confirmed positive results?

___YES ___NO

If you have any doubts about whether you should attend a scheduled appointment due to not feeling well or have answered **YES** to any of the above questions, then you **must** call the clinic to reschedule or make your appointment in 14 days. _____Initial

_____
Print Name

_____ _____
Patient Signature Date

Healing Tree Physical Therapy Wellness
1100 Central Avenue, Suite G | Wilmette, Illinois 60091
Phone: (847) 512-4070 | Fax: (779) 552-8891

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): ( ) -		

RELEASE OF INFORMATION/ FINANCIAL POLICY FORM

Thank you for choosing **Healing Tree Physical Therapy & Wellness** as your health care provider. The following is a policy that we require you to read and sign prior to any treatment.

Release of Information/ Medical Records

By signing this form, you authorize Healing Tree Physical Therapy & Wellness to release and disclose such medical records, information and documentation as may be necessary or appropriate in order to process insurance claims and to obtain payment on your behalf. You authorize the release of information acquired in the course of your examination or treatment and all information pertaining to your history and progress in your case. You agree that a photocopy of your original authorization shall be considered equally authentic.

Assignment of Benefits

By signing this form, you authorize assignment of your benefits for treatment and related services to Healing Tree Physical Therapy & Wellness. This means that your insurance company will pay us directly.

Regarding Insurance

We cannot bill your insurance company unless you provide us with your complete insurance information. We do attempt to obtain information about your therapy benefit coverage prior to your scheduled appointment. If you have any concerns about your insurance coverage, contact your insurance directly. Please be aware that some insurance companies will only provide some information with the member and not the provider, whether or not the services provided are covered under your benefit plan. NOTE: Verification of Physical Therapy benefits is **not** a guarantee of payment.

Your insurance benefits require, **payment of co-pays due at the time of service**. **Your insurance policy is a contract between you and your insurance company**. If your insurance plan changes during the course of your treatment, it is your responsibility to notify us of that change **before** it occurs. If you have received physical therapy at another facility during the current year, it is your responsibility to notify us of that as well. If you fail to do so, you will be responsible for any unpaid portion of your bill.

While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. If your insurance company has not paid your account in full within **45 days** of the billed date, the balance is your responsibility. Your assistance in collection from your insurance company may be required. In the event that your account becomes past due and is turned over to collections, you will be responsible for all cost of collections, including collection agency fees and all cost to file suit including attorney fees and court costs, if needed.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients. We charge what is usual and customary for our area. The federal government agency that administers the Medicare program, has determined that except for certain circumstances, the discounting or waiving or a patent's co-pay or deductible is unlawful. Additionally, under the new HIPAA regulations, we are now not allowed to discount or waive patient's co-pays or deductibles as outlined by benefits plans offered by other third-party payers. You are responsible for payment.

Refunds

There are times that an insurance company erroneously processes a claim, and the patient is due a refund. We will issue refunds, as soon as, your insurance company has made payment to Healing Tree Physical Therapy & Wellness.

Monthly Statement

If you have a balance on your account, we will send you a monthly statement. It will show separately each visit you were seen for, the payments made by your insurance company to those dates, any contract adjustments; other adjustments if applicable, co-pays and other payments you have paid, and late payment or appointment cancelation charges, if any. For any balance paid the previous billing cycle, these visits will not appear on future statements, unless it was a partial payment to a particular date of service. 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 Billing Office. **All balances not paid in full or per payment arrangement upon receipt of your monthly statement, will incur a 10% late payment fee.**

Cancellation/Missed Appointments Policy

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 and leave a voicemail at **(847) 512-4070** at least 1 business day/24 hours prior to the appointment time, during the business week. If you have an appointment on a Monday, we ask that you please call us on Friday to cancel. This assures us ample time to offer an appointment to patients on our waitlist. Please do not text to cancel your appointment, as we cannot always be sure it was received. **We reserve the right and will charge your account a fee of $100 for missed appointments or canceling your appointments with less than 1 business day/24-hour notice.**

Durable Medical Equipment/Supply Type

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 try to submit such items to your insurance on your own for reimbursement.

Auto Accident/Personal Injury Cases

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.

Bad Debt

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, a valid Credit Card, Money Order or Cashier's Check; personal checks will not be accepted.

Payments and Fees

Late Payment on Account Fee

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

Past Due Accounts

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.

Returned Check Fee

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 a valid 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

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?

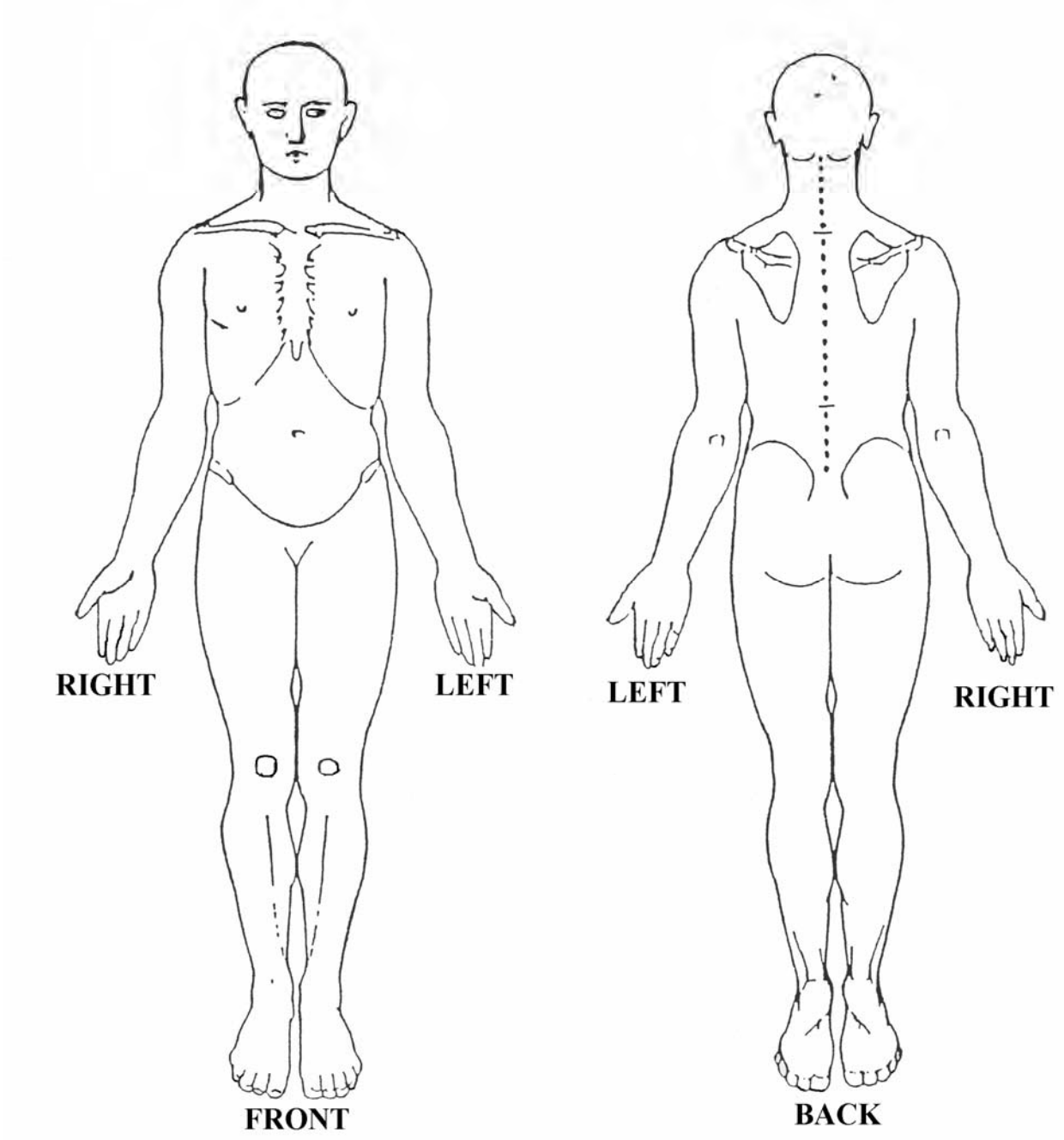
Heart Attack	Yes / No	Allergies	Yes / No	Heart Disease	Yes / No
High Blood Pressure	Yes / No	Hernia	Yes / No	Cancer	Yes / No
Dizziness	Yes / No	Diabetes	Yes / No	Stroke	Yes / No
Infections	Yes / No	Fibromyalgia	Yes / No	Bowel/Bladder	Yes / No
Metal Implants	Yes / No	Arthritis	Yes / No	Pacemaker	Yes / 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 _____



MEDICATION LIST

PATIENT INFORMATION		
Name:	**Date of Birth:**	**Date:**

CURRENT PRESCRIPTION MEDICATION		
MEDICATION	**DOSAGE**	**FREQUENCY**

OVER THE COUNTER SUPPLEMENTS AND VITAMINS		
OVER THE COUNTER SUPPLEMENTS & VITAMINS	**DOSAGE**	**FREQUENCY**

Healing Tree Physical Therapy & Wellness
1100 Central Avenue - Suite G
Wilmette, Illinois 60091
Phone: 847.512.4070 | Fax: 779.552.8891

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:** Yes ___ No ___ Email: Yes ___ No ___ **Text: 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.

**Texting will only be used for appointment related information and not be used for for finanical or medical information.

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:** _____