PATIENT REGISTRATION FORM

Please check which clinic you will be attending therapy.

{ } Belvidere Physical Therapy
{ } Edgebrook Physical Therapy
{ } Marengo Physical Therapy
{ } McHenry County Physical Therapy
{ } Ogle County Physical Therapy
{ } Poplar Grove Physical Therapy
{ } Sauk Valley Physical Therapy

Patient Information

Patient Name: _____ _____ _____ DOB: ___/___/___
(Last and suffix, i.e. Sr., Jr.) (First) (MI)

Social Security Number: _____ - _____ - _____ Gender: _____ Male _____ Female

Address: _____ City: _____

State: _____ Zip: _____ Marital Status: _____ Single _____ Married _____ Other

Home Phone: (_____) _____ Work/ Cell Phone: (_____) _____

Email address: _____

Referring Physician: _____ Primary Physician: _____

Patient/ Guardian Signature: _____ Date: _____

Employment Information

Employer Name: _____

Address: _____ Phone: _____

Occupation: _____ Status: _____ Full _____ Part Time _____ Retired _____ Unemployed

Guarantor/ Insured Information

(Individual responsible for payment, if different than patient)

Patient Relationship to Guarantor: _____ Self _____ Spouse _____ Child _____ Other

Name: _____ _____ _____ DOB: ___/___/___
(Last and suffix, i.e. Sr., Jr.) (First) (MI)

Social Security Number: _____ - _____ - _____ Gender: _____ Male _____ Female

Address: _____ City: _____

State: _____ Zip: _____ Marital Status: _____ Single _____ Married _____ Other

Home Phone: (_____) _____ Work Phone: (_____) _____

Guarantor Employer Name: _____

Employer Address: _____

Emergency Contact

Name: _____ Relationship: _____ Phone: (_____) _____

Name: _____ Relationship: _____ Phone: (_____) _____

Referral Information

(Please check and note how you heard of or were referred to this clinic)

□ Physician _____ □ Advertisement _____ □ Former patient _____
□ Event/ presentation_____ □ Fitness facility_____ □ Direct mailer_____
□ Other _____

(Revised 06.01.2018)

RELEASE OF INFORMATION/ FINANCIAL POLICY FORM

Please check which clinic you will be attending therapy.

{ } Belvidere Physical Therapy
{ } Edgebrook Physical Therapy
{ } Marengo Physical Therapy
{ } McHenry County Physical Therapy
{ } Ogle County Physical Therapy
{ } Poplar Grove Physical Therapy
{ } Sauk Valley Physical Therapy

Thank you for choosing the clinics of the Orthopedic and Sports Therapy Institute, Inc. as your health care provider. ***For the purpose of this form, the Orthopedic and Sports therapy Institute refers to the following clinics: Belvidere Physical Therapy, Inc., Edgebrook Physical Therapy, Inc., Marengo Physical Therapy, Inc., McHenry County Physical Therapy, Inc., Ogle County Physical Therapy, Inc., Poplar Grove Physical Therapy, Inc. and Sauk Valley Physical Therapy, Inc.*** Following is a statement of our Release of Information/ Financial Policy which we require you to read and sign prior to any treatment. All patients must also complete and sign our Patient Registration Form.

Release of Information/ Medical Records Initials _____

By signing this form, you authorize the clinics of the Orthopedic and Sports Therapy Institute, Inc. or his/ her designee(s) 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. This includes any alcohol or drug abuse data that may be protected by Federal Regulations- 42CFR Part 2. You agree that a photocopy of your original authorization shall be considered equally authentic.

Regarding Insurance Initials _____

We cannot bill your insurance company unless you provide us with your insurance information and any special claim forms required by your insurance company. We accept assignment of insurance benefits. That means your insurance will pay us directly the amount due based upon your benefit coverage. By signing this form, you authorize assignment of your benefits to the clinics of the Orthopedic and Sports Therapy Institute, Inc. for treatment and related services. However, we do require, as 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 this 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. ***Please know your benefits. Please be aware that only your insurance company can tell you if the services provided are covered under your benefit plan.***

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. **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 expenses up to 40% of the total account balance and all costs to file suit including attorney fees and court costs.**

Those insurance plans in which we are a participating provider.

All co-pays and deductibles are due at the time of treatment. Prior to seeking payment from you, we will work with these plans to obtain payment. In the event that your insurance coverage changes to a new plan in which we are not a participating provider, refer to the paragraph below.

Those insurance plans in which we are NOT a participating provider.

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.

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 and Medicaid programs, has determined that except for 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 unless we are a participating provider for your insurance company.

Patient Balances and Returned Check Fee
Patients are responsible for full payment at the time of service if not covered by some other third party such as Medicare, Medicaid or private insurance. Our returned check policy requires a $25.00 additional fee for each check returned.

Refunds
Due to the nature of our long-term relationship with our patients, we will issue refunds on a quarterly basis unless a specific request is made.

Cases Involving an Attorney Initials _____
If you are receiving services for an auto accident, worker's compensations case or personal injury and you are working with an attorney, we expect a minimum monthly payment of $25.00 in order to continue treatment. We also require information relating to your group health coverage. Your group health and the appropriate auto/ worker's compensation carrier will be billed at the same time unless instructed otherwise. This procedure is necessary in order to have a claim on file with the group health in case the auto/ worker's compensation carrier does not pay or is exhausted at some point during your treatment. The procedure not only protects the clinics of the Orthopedic and Sports Therapy Institute, Inc., but you as the patient as well.

Missed Appointments Initials _____
Please help us serve you better by keeping scheduled appointments. We recognize there are times when 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. If you miss a scheduled appointment our policy is to charge a **$25.00 fee** for missed appointments and you will be held responsible for payment.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)
HIPAA is a protective measure safeguarding patient privacy and confidentiality. By signing this agreement, I acknowledge that I have received information pertaining to my rights as covered under the Health Insurance and Portability and Accountability Act of 1996.

By my signature, I consent to receive Physical Therapy treatment as prescribed by my physician and given by a qualified licensed Physical Therapist. I have read and understand the above statements in the Release of Information/ Financial Policy concerning my payment responsibility.

X_____ _____ _____
Signature of Patient or Responsible Party | Print Name | Date

X_____ _____ _____
Signature of Co-Responsible Party | Print Name | Date

WE ACCEPT PAYMENT IN THE FORM OF CASH, PERSONAL CHECK, VISA OR MASTERCARD.

OSTI HEALTH QUESTIONNAIRE FORM

OSTI
Orthopedic and Sports Therapy Institute

Please check which clinic you will be attending therapy.
Please remember to bring your picture ID and insurance cards.

{ } Belvidere Physical Therapy
{ } Edgebrook Physical Therapy
{ } Marengo Physical Therapy
{ } McHenry County Physical Therapy
{ } Ogle County Physical Therapy
{ } Poplar Grove Physical Therapy
{ } Sauk Valley Physical Therapy

Patient Name: _____ Date:_____
DOB:___/___/_____ Age: _____ Height:_____ Weight:_____
Who referred you for physical therapy? _____
Please rate your general health status: (circle one) **Excellent** **Good** **Fair** **Poor**
Where are you currently having symptoms? _____
When did the symptom(s) begin (date)? _____
What do you think caused your symptoms? _____

My symptoms are currently: (circle one) **getting better / about the same / getting worse**

List 3 positions or activities that make your symptoms worse: _____
_____
List 3 positions or activities that make your symptoms better: _____
_____
Treatment received so far for this problem (chiropractic, injections, etc.):_____
_____
Please list special test performed for this problem (x-ray, MRI, labs, etc.):_____
_____
Have you had this problem(s) before? **Yes** **No** When? _____ Treatment? _____
How long did it take for you to feel better? _____

Body Chart:
Please mark the areas where you feel symptoms. Use the symbols to describe your pain:

Cramping +++

Sharp ***

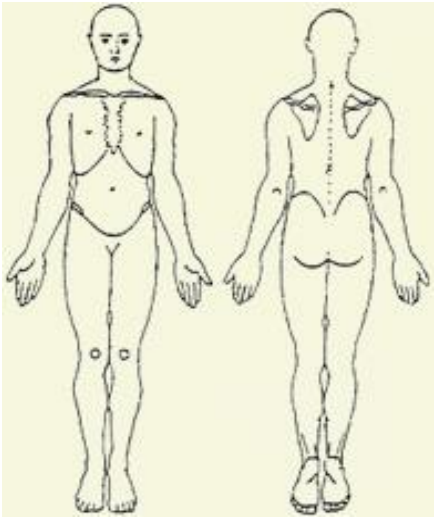
Aches ^^^

Tingling 000

Numbness ===

Stabbing ///

Burning XXX



(Revised 06.01.2018)

Current limitations: (check all that apply)

□ Difficulty with movement
□ Getting up/down form a chair
□ Walking: □ Level □ Stairs
□ Getting in/out of bed or changing positions in bed
□ Difficulty with dressing, bathing, and/or grooming
□ Ramps □ Uneven terrain

□ Difficulty with home management (household chores, yard work, driving, shopping): _____
_____

□ Difficulty with community and work activities (work, school, play, recreation): _____
_____

When answering these questions, think of the pain you are experiencing related to the problem for which you are having treatment. Circle 1 number for each of the 4 questions. On average, how bad has your pain been:

	No pain										Worst pain
1. In the morning over the past 2 days?	0	1	2	3	4	5	6	7	8	9	10
2. In the afternoon over the past 2 days?	0	1	2	3	4	5	6	7	8	9	10
3. In the evening over the past 2 days?	0	1	2	3	4	5	6	7	8	9	10
4. With activity over the past 2 days?	0	1	2	3	4	5	6	7	8	9	10

Please list all current medications: _____
_____

List any medications you are **allergic** to:

_____

Do you drink alcohol? **Yes No** Do you smoke? **Yes No** Do you have a pacemaker? **Yes No**

Please list any past surgeries or other conditions for which you have been hospitalized, including dates:

_____

Have you **RECENTLY** experienced any of the following (check all that apply)?

□ fatigue
□ fever/chills/sweats
□ dizziness/lightheadedness/fainting
□ shortness of breath
□ numbness/tingling
□ muscle weakness
□ weight loss/gain
□ difficulty with balance/falls
□ constipation or diarrhea
□ nausea/vomiting
□ headaches
□ bowel or bladder changes

Have you **EVER** been diagnosed with any of the following conditions (check all that apply)?

□ cancer
□ heart problems
□ chest pain/angina
□ high blood pressure
□ circulation problems
□ blood clots or stroke
□ bladder/urinary tract infection
□ anemia
□ bone or joint infection
□ depression
□ lung problems
□ tuberculosis
□ asthma
□ Rheumatoid arthritis
□ pneumonia
□ ulcers
□ kidney problem/infection
□ sexually transmitted disease/HIV
□ thyroid problems
□ diabetes
□ osteoporosis
□ multiple sclerosis (MS)
□ epilepsy/seizures
□ fibromyalgia
□ latex sensitivity
□ liver problems or hepatitis
□ Pregnancy: Past or Present

Have any of your immediate family **EVER** been diagnosed with any of the following conditions (check all that apply)?

□ cancer
□ heart problems
□ high blood pressure
□ diabetes
□ stroke
□ depression
□ tuberculosis
□ thyroid problems
□ blood clots

How are you able to sleep at night? (circle one)

No problem sleeping *Difficulty falling asleep* *Awakened by pain* *Sleep only with medication*

Patient/Guardian Signature: _____ Date:_____

Therapist Signature: _____ Date:_____