Patient Registration

Name_____Date_____

Address_____ Sex - Circle: M F

City_____State_____Zip_____

Home Phone _____ Cell Phone _____

Email Address: _____ Would you like to receive LWPT's Newsletter? Yes No

Age_____ Date of Birth_____ Marital Status S M W D

How did you hear about Living Well Physical Therapy? Circle:

Doctor Friend Family Member Insurance Company Internet Search Other

Who shall we thank for referring you? _____

If you found us via internet search or "other", what made you choose to come to Living Well Physical Therapy?

_____

Occupation_____Employer_____Phone#_____

Employer Address_____

Referring Physician_____ Phone#_____
Address_____Fax#_____

Reason for today's Visit _____Date accident/injury/illness_____

Please describe_____

_____

Policyholder/Responsible for this account _____
Relationship to patient_____Policy Holder's date of birth:_____
Address if different from above_____

Primary Insurance Co. Name_____
ID#_____ Group # _____
Address_____ State____ Zip Code _____

Secondary Insurance Co. Name _____
ID# _____ Group #_____
Address_____ State ____ Zip Code_____

Have you received any Physical Therapy, Occupational Therapy, Chiropractic Therapy or Speech Therapy in this calendar Year? Y N

If yes, please list the number of visits during THIS CALENDAR YEAR, including those at any other location:

PT number of visits: _____ OT number of visits _____ CT number of visits_____ ST number of visits _____

Medicare patients only: Have you received any In-Home Healthcare services in the last 3 months? Y N

Work Comp/ Auto / Personal Injury
Prior to your initial evaluation LWPT will need the following documentation:
1. The name of the insurance carrier on the insurance company's letterhead with verification of claim number, contact person, phone number and address as to where the billing should be sent.
2. LWPT will have to verify this information prior to the initial evaluation. Please note: under the laws of the State of Illinois LWPT/A^2 Alternative Pain Management will claim a lien of said injured person for the amount of reasonable charges up to the date of payment of damages.

Responsible Party Statement: As the responsible party, I agree that all charges not directly paid by my insurance company will be my responsibility. Co-pay's, co-insurance, deductibles, non-covered or denied services are the responsibility of the responsible party/patient. You are required to pay your billing statements within 30 days of receipt. After 90 days, we reserve the right to send all outstanding balances to collection and/or pursue all legal options available to collect monies due us, including all applicable handling and legal charges incurred by our office. Insurance is a contract between you and your insurance company. **Please call your insurance company to verify exactly what they will cover for physical therapy and/or naprapathy services.** We file claims as a courtesy to our patients.

Assignment of Benefits/Authorization to Release Medical Information/Consent to Treatment
I hereby assign all medical benefits to which I am entitled to Living Well Physical Therapy/A^2 Alternative Pain Management in the event they file insurance on my behalf. I understand that I am financially responsible for all charges whether or not paid by said insurance. Verification of benefits is not a guarantee of payment. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. A copy of this assignment shall be considered as effective and valid as the original. I authorize Living Well Physical Therapy and/or A^2 Alternative Pain Management to release any information acquired in the course of my treatment necessary to process insurance claims or to discuss my treatment plan with other practitioners. I do hereby consent to such treatment by the authorized personnel of Living Well Physical Therapy, Inc., and/or A^2 Alternative Pain Management, as may be dictated by prudent medical practice by my illness, injury, or condition. This consent is intended as a waiver of liability for such treatment excepting acts of negligence.

Signature_____ Date _____

Medical History Form

Name: _____ DOB: _____ Date: _____

Occupation:_____

Allergies:
List any medication(s) you are allergic to: _____
Are you latex sensitive? Yes No List any other allergies:_____

What brings you to physical therapy? _____

What do you hope to achieve by coming to physical therapy? _____
_____

How long have you had this problem? _____
Onset: □ Sudden □ Gradual Date of Injury? _____

Who have you seen for your current condition? □Primary MD □Orthopedic MD □PT □ Chiropractor □Other, _____
What Tests or Procedures have been done for your current condition? Date of test(s)?
X-Ray_____ MRI/CT scan_____ Bone Scan_____ EMG_____ Blood Work_____ Other_____

Where did your pain start? _____
Where did it spread to? _____

Since it started, pain is: □ getting worse □ improving □ the same
Describe the pain: □sharp □dull □aching □burning □throbbing □shooting □cramping □stabbing □sore □squeezing
□ other, describe:
_____

What makes symptoms worse? (*Check all that apply)*
□ Sitting □ Standing □ Laying down □ Walking □ Going Up Stairs □ Going Down Stairs
□ Touch (what body part?) _____ □ Movement (what body part?) _____ □ None apply

What makes it better? _____
Does time of day affect your pain? _____Do you wake from sleep due to pain?_____

Rate your pain on 0-10 scale (0 is no pain, 10 is the worst you can imagine)

Pain at its least:	0	1	2	3	4	5	6	7	8	9	10
Pain at its worst:	0	1	2	3	4	5	6	7	8	9	10
Pain now:	0	1	2	3	4	5	6	7	8	9	10

Check any activities you have difficulty with due to the problem for which you are seeking treatment:
□ sleeping □ rising from a chair □ bathing □ dressing □ prolonged sitting (30min. +) □ driving □ meal preparation
□ waking □ using stairs □ prolonged standing □ eating □ reaching shelves □ self-care □ getting in/out of bed □ other

How many times have you fallen in the past year? _____ If so, what happened? _____
_____

During the past month have you been feeling down, depressed or hopeless? Yes No (circle one)
During the past month have you been bothered by having little interest or pleasure in doing things? Yes No

Past Medical History (please check "yes" if you have ever been diagnosed with any of the following)

Note: If you are unsure about a particular item, please leave it blank and discuss this with your therapist

	Yes	No
Auto Immune Disease		
Systemic Arthritis (RA, Lupus, Other)	☐	☐
Unexplained rashes, sores or swelling	☐	☐
Fibromyalgia/Chronic Fatigue	☐	☐
Blood Disorders		
Bleeding disorders	☐	☐
Clotting disorders	☐	☐
History of DVT (Blood Clots)	☐	☐
Currently taking blood thinners	☐	☐
Peripheral Vascular Disease (PVD)	☐	☐
Cancer		
History of cancer, any type	☐	☐
Cardiovascular		
Heart Attack	☐	☐
Chest pain or Angina	☐	☐
Fainting	☐	☐
Heart rate restrictions w/exercise (per MD)	☐	☐
High Blood Pressure	☐	☐
Endocrine/Metabolic		
Diabetes	☐	☐
Osteoporosis	☐	☐
Thyroid Problems	☐	☐
Immunologic		
HIV	☐	☐
HEP B, HEP C	☐	☐
Neurologic		
Stroke/TIA	☐	☐
MS/Parkinson's	☐	☐
Seizure Disorder	☐	☐
Poor balance/frequent falls	☐	☐
Recent tremors or clumsy walking	☐	☐
Numbness/tingling both hands or feet	☐	☐

	Yes	No
Other		
Currently pregnant	☐	☐
Do you have a pacemaker	☐	☐
Do you have metal implants	☐	☐
Severe cold intolerance	☐	☐
Poor tolerance to NSAID's	☐	☐
Severe food or drug allergies	☐	☐
Vision or hearing difficulties	☐	☐
Depression	☐	☐
Constitutional Symptoms		
Fever/Chills/Night Sweats	☐	☐
Severe fatigue/Malaise	☐	☐
Nausea/Vomiting	☐	☐
Dizziness/Fainting	☐	☐
Unexplained weight loss	☐	☐

Other: Please include any additional information that would be beneficial in helping us with your care.

Surgeries/Hospitalizations *(include date and reasons)*

1) Date _____ Reason: _____
2) Date _____ Reason: _____
3) Date _____ Reason: _____
4) Date _____ Reason: _____
5) Date _____ Reason: _____

Medications *(include prescribed and over-the-counter)*

Name	Dose	Reason

To the best of my ability, I have given and included all pertinent medical information.

_____ _____
Patient/Guardian Signature Date

Medical history reviewed by physical therapist and used in determining the plan of care.

_____ _____
Therapist Signature Date

Living Well Physical Therapy, Inc., Privacy Notice:

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your Medical Records

Living Well Physical Therapy, Inc. creates and maintains a medical record each time you are treated at our office. Your diagnosis, injuries, evaluation, test results, treatment, and plan of care are documented. This information is referred to as your "medical record" and is the means through which we plan your treatment and communicate to other health professionals who contribute to your care. Understanding what information is retained in your record and how that information may be used will help you to ensure its accuracy, and enable you to relate to who, what, when, where, and why others may be allowed access to your health information. This effort is being made to assist you in making informed decisions before authorizing the disclosure of your medical information to others.

Your Healthcare Information Rights

Your medical record is the physical property of Living Well Physical Therapy, Inc. However, because this record consists entirely of details regarding your care, you have the right to inspect and obtain a copy of your health information and be given an account of all disclosures. You also have the right to request restrictions on certain uses and disclosures of your information, and to request amendments be made to your medical record. You may also request that confidential communication by us regarding your medical information be made by alternative means or to alternative locations. Other than activity that has already occurred, you may revoke any further authorizations to use or disclose your medical information. If you receive this notice electronically, you are entitled to receive this notice in written form.

Our Duties

Living Well Physical Therapy, Inc. is required to maintain the privacy of your medical information and to provide you with notice of our legal commitment and privacy practices with respect to the information we collect and maintain about you. Living Well Physical Therapy, Inc. is required to abide by the terms of this notice and to notify you if we are unable to grant your requested restrictions or reasonable desires to communicate your medical information by alternative means or to alternative locations. Living Well Physical Therapy, Inc. reserves the right to change its practices and effect new provisions that enhance the privacy standards of all patient medical information. In the event that changes are made while you are receiving care, Living Well Physical Therapy, Inc. will notify you at your next appointment or at the current address provided in your medical file. Other than for reasons described in this notice, Living Well Physical Therapy, Inc. agrees not to use or disclose your medical information without your authorization.

To Receive Additional Information or Report a Problem

For further explanation of this notice you may contact our Privacy Officer at 847-247-9133. If you believe your privacy rights have been violated, you have the right to file a complaint with the Secretary of Health and Human Services with no fear of retaliation by Living Well Physical Therapy, Inc.

Treatment – Information obtained by your therapist at Living Well Physical Therapy, Inc. will be recorded in your medical record and used to determine the course of treatment. This consists of your therapist recording his/her own expectations and those of others involved in providing your care. The sharing of your health information may progress to others involved in your care, such as physicians.

Payment – Your medical information will be used in order to receive payment for services rendered by Living Well Physical Therapy, Inc. A bill may be sent to either you or a third party payer with accompanying documentation that identifies you, your diagnosis, procedures performed and supplies used.

Healthcare Operations – The medical staff at Living Well Physical Therapy, Inc. will use your medical information to assess the care you received and the outcome of your case compared to others like it. Your information may be reviewed for risk management or quality improvement purposes in our efforts to continually improve the quality and effectiveness of the care and services we provide.

Living Well Physical Therapy's policy for specific disclosures to Business Associates – Some or all of your medical information may be subject to disclosure through contracts for services to assist Living Well Physical Therapy, Inc. in providing health care. To protect your health information, we require these Business Associates to follow the same standards held by Living Well Physical Therapy, Inc., through terms detailed in a written agreement.

Notification – Your medical record may be used to notify or assist family members, personal representatives, or other persons responsible for your care to enhance your well-being or your whereabouts.

Communications with Family – Using best judgment, a family member or close personal friend - identified by you - may be given information relevant to your care and recovery.

Worker's Compensation - Living Well Physical Therapy, Inc. will release information to the extent authorized by law in matters of worker's compensation

Public Health - Living Well Physical Therapy, Inc. is required by law to disclose medical information to public health and/or legal authorities charged with tracking reports of birth and morbidity. Living Well Physical Therapy, Inc. is further required by law to report communicable disease, injury, or disability.

Law Enforcement – (1) Your medical information will be disclosed for law enforcement purposes as required under state law or in response to a valid subpoena. (2) Provisions of federal law permit the disclosure of your medical information to appropriate health oversight agencies, public health authorities, or attorneys in the event that a staff member or business associate of Living Well Physical Therapy, Inc. believes in good faith that there has been unlawful conduct or violations of professional or clinical standards that may endanger one or more patients, workers, or the general public.

Confirmation and Cancellation Policy - In order to avoid the $50.00 cancellation fee, please provide our office with a 24-hour notice when canceling your appointment.

Notice of Privacy Practices Availability

All individuals receiving care will be given a hard copy of the terms described in this Notice and asked to acknowledge receipt. This Notice takes effect on December 23, 2008, and will remain in effect until we replace it.

I have read the Privacy Notice and understand my rights contained in the Notice. By way of my signature, I provide Living Well Physical Therapy, Inc. with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in this Privacy Notice.

_____ _____

Patient's Signature **Date**