Be Fit Physical Therapy & Pilates, LTD

Patient Registration Form

Date:____________________

Name:____ Birthdate:______________________ Age:______________

Address:________________________________ City, State, ZIP:____

Preferred Phone # (Home)(Cell)(Work):__________________________ Marital Status: M ☐ S ☐ W ☐ D ☐

Secondary Phone# (Home)(Cell)(Work):__________________________ SS#______________________________

E-Mail Address:____ Sex: F ☐ M ☐

INSURANCE INFORMATION:

Name on insurance card:____________________________________ Their date of birth:_________________

Relationship to primary card holder:______________________________

Emergency Contact: ________________________ Phone# ____________________Relationship: ________________

Referring Physician: __________________________ Phone: _____________________ Fax: __________________

Family Physician: ___________________________ Phone: ______________________ Fax: __________________

Patient Employer: ________________________ Job Title: _______________________ Phone: _______________

Address:______________________________ City, State, ZIP: ____

Injury Information:

Is your condition a result of (Please Check One):

Work Related ☐ Injury ☐ Auto Accident ☐ Other: (Please Explain) ___________________________________

When was the date of Injury/Accident/Other: ____________________________

Workman's Compensation / Attorney / Insurance Representative / Other contact information:

Name:_____________________________ Phone #: __________________ Company: __________________________

*** If Worker's Compensation please supply a copy of authorization and billing information.**

Release of protected health care information via telephone to answering machine or voice mail.

I give my consent and authorization for the Medical or Billing Staff of Be Fit Physical Therapy & Pilates, LTD., to leave protected health care information about me or for me on any answering machine or voice mail via the telephone at the number I have listed below. I understand I revoke this privilege at any time by submitting my request in writing to retrieve results of all test and procedures.

Phone number: ____________________Signature: ______________________________ Date: ________________

Restrictions (s): ____

Pursuant to Health insurance portability and Accountability Act of 1996, I acknowledge that I have received a copy of the Notice of Privacy Practice. Initial: _______________ Date: ____________________

Consent for Treatment & Release of Information
Insurance Authorization and Assignment of Benefits

I Authorize Be Fit Physical Therapy & Pilates, LTD to deposit checks received on my account when made out to me. I understand if the insurance company sends payment directly to me, I am responsible for returning payment over to Be Fit Physical Therapy & Pilates, LTD upon receipt of the check. Failure to do so will result in me being responsible for the total balance due on the account in full. I understand that I AM RESPONSIBLE for any and all charges, costs, and fees incurred during my evaluation and treatment program at Be Fit Physical Therapy & Pilates, LTD., not covered by my insurance carrier(s). ***In the case of no insurance coverage, I am responsible for payment in full.***

If I am unable to pay the balance until paid in full, it is my responsibility to make financial arrangements and make regular payments on my account balance until paid in full. Further, I understand that all delinquent accounts are turned over for collection to a third party agency if no payment is received for 75 days. This agency does report to all credit bureaus for recording on personal credit history. If I fail to pay for my physical therapy services, I agree to pay the collection agency fees, attorney fees, and court costs incurred in collecting the dept. I consent to the above billing procedures as confirmed by my signature below.

I or my (spouse, child, dependent) has a condition, which a licensed physician has prescribed physical therapy as part of the treatment plan. I request and consent to Be Fit Physical Therapy & Pilates, LTD and its physical therapist, assistants, and professional staff, to perform therapeutic procedures that my be necessary for my rehabilitative treatment as necessary and desirable in the exercise of professional judgment. It is not possible to make guarantees concerning the results of this or any treatment. I acknowledge that no such guarantees have been made to me. I also authorize Be Fit Physical Therapy & Pilates, LTD to obtain and release any medical information, verbal or written, necessary to provide appropriate patient care. I understand that all information exchanged is maintained under the Be Fit Physical Therapy & Pilates, LTD confidentially policy.

Cancellation/No Show Policy

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment.

If your appointment is not cancelled at least 24 hours in advance, you will be charged a $25.00 fee; this will not be covered by your insurance company.

Patient Initials: __________

Patient Signature:____________________________________ Date: ___________________________

Witness Signature: ____________________________________ Date: ___________________________

Be Fit Physical Therapy & Pilates, LTD
MEDICAL INFORMATION

To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you do not understand a question, we will be happy to assist you. Thank you.

Name: ____ **Age:** ______________ **DOB** _____________________

Occupation: ___________________________ **Leisure Activities:** ____________________________________

Please circle any of the following medical professional you are currently seeing:

Medical Doctor Osteopath Physician Assistant Physical Therapist Chiropractor Dentist Nurse Practioner

If you have been seen by any of the above during the last three months, pleas describe for what reason (illness, medical condition, physical examination, ect.)

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Please circle any of the following condition that you have EVER been diagnosed with and describe below

High/Low blood pressure	Heart Problems	Thyroid problems	Diabetes	Emphysema	Asthma
Chemical Dependency	Alcoholism	Multiple sclerosis	Hepatitis	Depression	Stroke
Rheumatoid arthritis	Tuberculosis	Kidney disease	Anemia	Epilepsy	AIDS
Other Arthritic Conditions	Cancer	Other			

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Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization:

Date: **Surgery/ Hospitalization:**

______ ____

______ ____

______ ____

Please describe any injures for which you have been treated (including fractures, dislocations, sprains) and the approximate date of injury:

Date: **Injury:**

______ ____

______ ____

______ ____

Please circle the condition below that any in your immediate family (parents, brothers, sisters have ever been treated for?

High/Low blood pressure	Heart disease	Kidney disease	Diabetes	Chemical Dependency
Alcoholism	Kidney Disease	Tuberculosis	Epilepsy	Mental Illness
Arthritis	Headaches	Stroke	Anemia	Cancer

Please circle the following OVER-THE-Counter medication you have taken in the last week.

Advil	Motrin	Ibuprofen	Tylenol	Decongestants
Vitamin	Antacids	Laxatives	Antihistamines	Others: ________________

Please list any PRESCRIPTION medication you are currently taking: (pills, injections, and/or skin patches)

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Please list any Drug, Food, Seasonal, or Product ALLERGIES:

____

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Is there anything else you would like for us to know?

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Please circle either the correct answer to the question below:

Have you currently experienced:

Yes	No	Weight loss/ Gain
Yes	No	Nausea/ Vomiting
Yes	No	Fatigue
Yes	No	Weakness
Yes	No	Fever/ Chills/ Sweats
Yes	No	Numbness or Tingling
Yes	No	Bladder or Bowel changes

Are you dizzy right now? Yes ☐ No ☐

If yes, please mark the areas on the scale below.

On the following scale of 0 – 10, how would you rate your dizziness?

No dizziness | Moderate dizziness | Extreme dizziness

0 1 2 3 4 5 6 7 8 9 10

Dizziness is: ☐ constant ☐ intermittent ______________________________

Due to your condition do you have difficulty:

☐ walking ☐ balancing
☐ sleeping ☐ getting up from bed/chair
☐ personal care activities (dressing, washing, etc.) driving
☐ performing work duties
☐ performing light domestic duties
☐ performing heavy domestic duties
☐ performing your recreation/sport activities
☐commuting/traveling

Do you have other symptoms?

☐stiffness ☐ weakness ☐ tenderness ☐ tightness
☐limited motion numbness ☐ tingling sensation
☐others:____

What are your goals? ____

____

How did you hear about Be Fit Physical Therapy? ____

____

_________________________________ ____________________

Patient/ Guardian Signature **Date**

Patient Privacy Policy & Procedure Statement

1027 Burlington Ave
Downers Grove, IL 60515
Phone: (630)964-4008
Fax: (630)964-4117

Dear Patient:

Be Fit Physical Therapy & Pilates LTD maintains compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy regulations passed into law on December 20, 2000.

We obtain your voluntary consent to provide treatment, release medical records to the appropriate entities and those who you designate to provide health care treatment, payment, and daily operations of the facility.

Our clinical and front office staff uses patient information to ensure quality care and appropriate billing for services.

You may correct, amend, access, and request a copy of your medical record and access history by signing a letter for release of your medical information. The cost for copies of medical records is in accordance with state law.

We protect all patient information within the guidelines provided by federal, state, and local government.

If you have any grievance pertaining to the privacy of medical records or wish to inquire further about how our facility manages patient information, please contact our Privacy Officer at 630-964-4008.

Be Fit Physical Therapy & Pilates LTD reserves the right to amend, change, and/or revise our privacy policy at any time in accordance with federal, state, and local rules, regulations, and guidelines.

Thank you for choosing our health care facility.

Signature ______________________ Date ____________
Patient / Guardian

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