Achieve Orthopedic Rehab Institute

www.achieveortho.com

CREDENTIALED RESIDENCY PROGRAM

Patient Information

Patient Name: Nickname:	Date of Birth:
Patient Address:	City/State/Zip:
Patient Phone:	Patient Cell Phone:
Patient SSN:	Email Address:

Spouse Information

Spouse Name:	Spouse Date of Birth:
Spouse Employer:	Spouse Phone:

Patient's Employer Information

Employer Name:	Employer Phone:
City/State/Zip:	Occupation:

Emergency Information

Contact Name:	
Contact Phone:	Contact Relation:
Primary Care Physician:	**Referring Physician:**
Primary Care Phone:	**How did you hear about us?:**

Have you had any therapy this year? **PT, OT, ST, Chiropractic, Pulmonary, Cardiac. If so, visit count?**	□ Yes Number of visits used?	□ No
When?		
Where?		

Primary Insurance Company:		**Secondary Insurance Company:**	
Policy ID:		Policy ID:	
Group #:		Group #:	
Policy Holder:		Policy Holder:	
DOB:		DOB:	

Injury Case: □

Injury Date:					
Employee Related:	□ Yes	□ No	Auto Related:	□ Yes	□ No
Post-Operative:	□ Yes	□ No	W/C Claim:	□ Yes	□ No
Other Accident:	□ Yes	□ No	W/C Claim Number:		

Worker's Compensation: □

W/C Carrier:	W/C Phone:
W/C Address:	W/C City & State:

Attorney: □

Attorney Name:	Attorney Phone:
Attorney Address:	Attorney City & State:

We strive to provide you with the most accurate benefit information this, however, is not a guarantee of coverage. Should you feel that the information provided to you may be in error, we encourage you to contact your insurance carrier. Co-Payment amounts are specified by the terms of the member's benefit agreement and are the Patient's responsibility at the time of service. These fees are not negotiable.

I herby authorize the above information as accurate. Any remaining unpaid balance will be my responsibility.

Signed: _____ Date: _____

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Patient Health Information Consent Form

We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. A HIPAA NOTICE is available to you at the front desk should you require more detailed information.

- The patient understands and agrees to allow this Achieve Orthopedic Rehab Institute to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow Achieve Orthopedic Rehab Institute to submit requested information to the Health Insurance Company provided to us by the patient for the purpose of payment.

- The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections, please keep in mind that when requesting records a fee may apply. The patient may request to know what disclosures have been made. Should any restrictions be submitted in writing, our office is not obligated to agree to those restrictions.

- A patient's written consent need only be obtained one time for all subsequent care given the patient in this office. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

- We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them. Patients have the right to file a formal complaint about any possible violations of these policies and procedures.

- If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the Achieve Orthopedic Rehab Institute Physical Therapist has the right to refuse care.

Consent for Release and Use of Confidential Information

I hereby give my consent to Achieve Orthopedic Rehab Institute to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record.

I understand that the physical therapist has reserved a right to change his or her privacy practices that are described in the notice. I also understand that a copy of any revised notice will be provided to me or made available at the office visit.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physical therapist. I also understand that I will not be able to revoke this consent in cases where the physical therapist has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physical therapist's office.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ / / _____

Name of Patient/Guarantor Signature Date

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CONSENT/AUTHORIZATION FORM

Achieve Physical Therapists:

- □ Ashraf Abdelhamid, PT, PhD, DPT, MS, OCS, CMTPT
- □ Robert Johnson, PT, DPT, MS, OCS, CTPS
- □ Philip A Kushner, PT, DPT, OCS
- □ David McCartney, PT, MS, OCS, ATC
- □ Gina M Pongetti Angeletti, PT, MPT, MA, CSCS
- □ Katarzyna Sacha, PT, OCS, FAAOMPT

CONSENT FOR TREATMENT: I authorize any of the above-named physical therapist(s), to perform treatments including but not limited to: Therapeutic Exercises, Pain Treatment Modalities (interferential ultrasound, e-stimulation, ice, and/or heat) and Manual Therapy.

I also certify that no guarantee or assurance has been made as to the results that may be obtained. I have read and understand the above. I consent to participate in the evaluation and treatment offered to me. I understand that I may stop treatment at any time.

RELEASE OF MEDICAL RECORD: In order to ensure proper follow-up and continuity of care, I agree that a copy of my medical record may be released to my physician, a designated referral physician, and/or the referral provider. I hereby authorize **Achieve Orthopedic Rehab Institute** to release to my insurance company any information acquired in the course of my examination or treatment which is necessary to process claims for services rendered.

_____
Initial

I authorize **Achieve Orthopedic Rehab Institute** to discuss my medical condition with another person (spouse, care-taker, attorney, family member, other)

_____
Initial

Please let us know whom you authorize: _____

PHONE MESSAGES: I authorize **Achieve Orthopedic Rehab Institute** to leave a message on my answering machine as needed.

_____
Initial

INSURANCE AUTHORIZATION: I request that payment of authorized benefits be made to the above-named therapist(s) on my behalf for any services provided to me. I authorize a release of any medical and/or patient information needed to determine benefits or benefits for related services to any insurance company, any other third party payer, state medical assistance agency and/or any other governmental private payer responsible for paying such benefits. I agree to pay for all my charges not covered. I authorize a copy of this authorization to be used in place of the original.

LATE/CANCELLATION/NO SHOW POLICY: In an effort to be as available to our patients as possible we ask that you give 24 hour notice of cancelling an appointment. Should you be running late please contact the office to confirm that they will still be able to accommodate your visit. We recognize that punctuality is not always possible but we appreciate your understanding. Please note that if you fail to keep two consecutive appointments and have not called to reschedule, your subsequent appointments will be cancelled.

Signed: _____ Date: _____

Insurance/Payment Collections Agreement
Starting January 1st, 2018

STAFF: Reviewed Initials:_____
Date Reviewed: _____

Thank you for your commitment to maintaining the ability to provide quality healthcare to all while respecting the hard work of the therapists, staff and owners of Achieve Manual Physical Therapy and Achieve Sports Medicine. We look forward to being on your journey to health and wellness!

As a courtesy to our patients, Achieve bills insurance companies directly. From the day that treatment occurs, a process must be followed by completing the documentation for treatment and submitting the claim to the insurance company. Each payer has a different time lapse before a claim is processed for your treatment. As a participating provider in the payer network, we agree to this lapse as it is a part of our contractual agreement.

1) Co-payment (Definition: This is a set amount assigned by your insurance company per visit, no matter what level of the treatment) MUST be paid at the time of service, or the service for that day will not be rendered and a $75 cancellation fee will be charged.

____ I understand and agree that each copay will be paid at time of service or a lump sum within the week. I will pay my co-payment that has been explained to me based on the Insurance Verification Sheet provided by the Front Office Manager at the time of the initial evaluation.

_____ I understand and agree that if a payment method is not provided, it will count as a "cancellation" of visit by the patient, and therefore a $75 cancellation fee will be charged to the credit card on file.

2) Deductible. (Definition: A predetermined amount by your insurance company that is patient responsibility prior to insurance coverage). This amount is based on the benefit information received during an insurance verification from your insurance plan/company. The deductible is a separate cost from the co-insurance and co-pay amounts. For example, if your co-insurance coverage states you are responsible for 20% and the insurance covers 80%, the deductible still **MUST BE MET** prior to the cost sharing responsibility begins (i.e. co-insurance and co-pay). Achieve's policy is to collect an "estimated" amount as payment toward your account balance until your deductible is met. Each individual session is billed based on services rendered, so the amount collected may not cover all services provided (insurance companies have negotiated rates that vary).

____ I understand and agree to a "per visit charge" toward my balance until my deductible is met, based on the benefits estimate from my insurance plan/company.

3) Co-insurance (Definition: This is a cost sharing percentage of responsibility that the patient has to pay after co-pay and deductible amounts have been applied). This percentage cannot be collected at the time of service, as each day of service may vary in billing, pending the treatment administered by the therapist and the negotiated rate that the insurance company allows for reimbursement.

____ I understand and agree that when I receive an EOB (Explanation of Benefits) from my insurance company, and then a bill from Achieve, that I am responsible for submitting PAYMENT IN FULL within 30 days of receipt of this statement.

4) Patient Responsibility. At the initial evaluation, all patients are explained, in detail, the facets of their insurance benefits (including but not limited to: visit limits, dollar amount limits, code limitations, deductible amounts met quoted by the insurance company and more). By engaging in treatment at Achieve, **it is the patient's full responsibility** (or their guarantor/guardian) to pay for these services. Patients will be charged 10% per month interest on any bill that is 30 days past due (after 2 statements have been mailed), without exception.

_____ I understand and agree that if balances are not paid IN FULL with no exceptions in the time allotted (30 days), after mailing 2 statements, Achieve will directly bill your credit card on file.

_____ I understand and agree that I will be charged interest (10% per month) on any bill that is more than 30 days overdue from the time of sending 2 statements.

5) Self Pay. There is a self-pay option for physical therapy treatments that still need to be scripted (referred) by an MD (state of IL licensure requirement for ALL physical therapists).

_____ I understand and agree that if I am a self-pay (non-insurance billed) patient, my payment IN FULL is due at the time of service.

6) Cancellation and No-Show policy. We understand that life gets busy, and people get sick, as well as schedules may be at times out of our control. We at Achieve take pride in making sure that our therapists and staff get 1:1 time with each patient at their appointments. Therefore, by scheduling your appointment, you are "reserving" time. When you are not present for said appointment, this time is unused, but we still have the responsibility of paying our staff for their time. A charge of $75 will be automatically billed to your CCOF (see #7 below) if appointment is not cancelled within 24 hours of your appointment. There is a one-time courtesy to patients (not including their initial evaluation) for being sick, scheduling conflict, etc. Individual cases may be considered by front office and management when/if extenuating circumstances occur.

7) Credit Card on File (CCOF). It is difficult to collect balances as people often forget forms of payment, minors are patients and parents are not present each treatment (after signing the Consent to Treat Minor form) or lives get busy and bills get overlooked. At times, patients simply do not pay their bills. As a result of this, we will be requiring to keep a valid Credit Card on file for the following circumstances:
* Balances over 30 days due with 2 statements and Achieve's receipt of our EOB. Treatment will NOT be provided if this is not agreed to.
* If you, as a patient, are on time with co-insurance payments, any remaining deductible above and beyond the daily charge per insurance, and balances of bills, your Credit Card on file may never be used. However, if this is not the case, Achieve's policy is to charge for the services rendered in fairness to the business as the patient has already received the services.

I understand and agree that my Credit Card on file will be charged without transactional consent, for the following (initial each individually):

1. _____Co-payments that are missed (at the end of each week),
2. _____Co-insurance that is not paid within 30 days of 2 statements being mailed,
3. _____Appropriate cancellation/no show fees – charged at time of missed appointment.
4. _____ Deductible balance within 30 days of not receiving payment from time of 1 statement.
5. _____ Any other balance (to include but not limited to durable medical equipment purchased (DME), surcharged services (ex: ionto patches, AlterG treadmill use, DorsaVi testing)

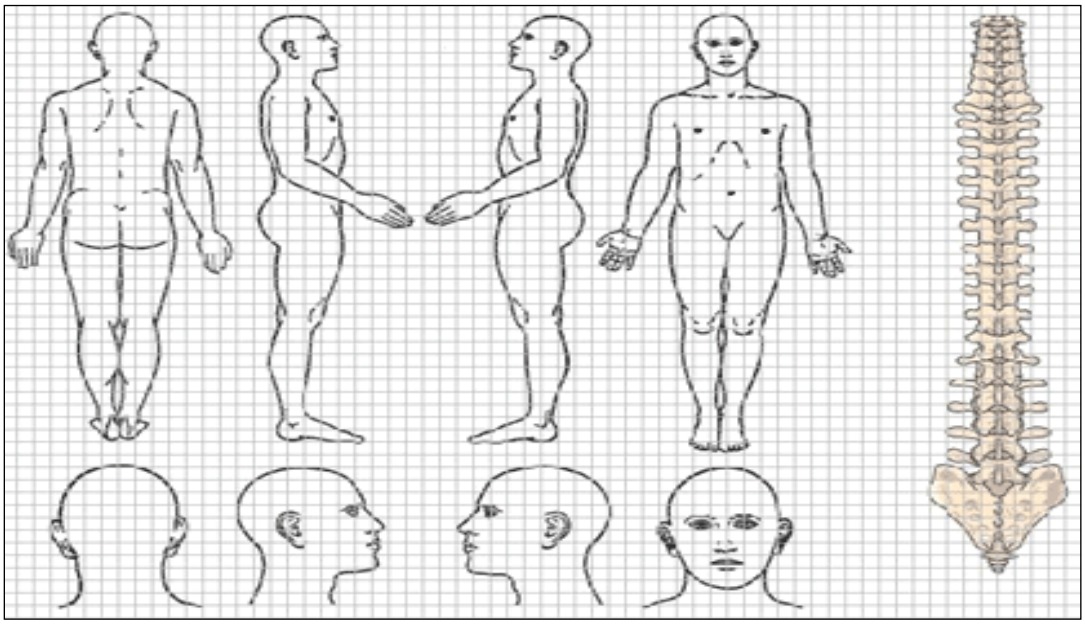
8) Patient Rights

_____ I understand that it is Achieve's Policy, and not law, that these stipulations for treatment must be followed, and that I may take my business elsewhere and choose to not be treated should I not agree to these statements. Physical Therapy is a voluntary procedure prescribed by a physician and the patient can choose or dismiss their providing company at will.

Patient Symptoms Report &Diagram

Name: _____**DOB:** _____/_____/_____

Mark the drawing according to where you hurt (ex: if the back of your neck has pain, circle the back of the neck, etc.). If you feel any symptoms, please indicate where you feel them by placing marks on the diagram. Include all affected areas.



Please circle the appropriate number below showing how bad your pain is now: **HEIGHT**_____**WEIGHT**_____

Now:	**No pain**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10** **Worst possible pain**
At Worst:	**No pain**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10** **Worst possible pain**
At Best:	**No pain**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10** **Worst possible pain**

1. **What is the purpose of Today's Evaluation?**
2. **Are you still working?** □ **Yes** □ **No** if not when was the last day on the Job**?**
3. **Occupation:**
4. **When (roughly what date) did your present pain start?**
5. **How did symptoms start?** (Check appropriate box)

□ No apparent cause □ Gradually □ Twisting □ Bending

□ Lifting □ Fall □ Pulling /Pushing □ Suddenly

□ **Injured during work** **Date:** ____/_____/_____	□ **Injured in auto accident** **Date:** ____/_____/_____	□ **Injured at sports** **Date:** ____/_____/_____

6. Have you had similar pain? □ Yes □ No □ Date ____/_____/_____

7. Have you been hospitalized for your pain problem? □ Yes □ No Date ____/_____/_____

8. How do you describe your pain? □ Constant □ Intermittent

9. What describes the nature of your symptoms?

□ **Sharp** □ **Shooting** □ **Burning**

□ **Dull ache** □ **Numb** □ **Tingling**

10. What activities make the pain:

	Better	Worse	No Difference	Comments
□ Exercise				□ During □ After
□ Lying down				□supine □ right side □ left side
□ Sitting				□ How long
□ Standing				□ How long
□ Walking				□ Distance
□ Bending				□ forward / backward □ right side □ left side
□ Overhead activities				
□ Lifting / pushing / pulling				
□ Coughing / Sneezing				
□ Pain Medications				
□ Other				

11. What medications are you currently taking? (If additional space is needed please use the back of this sheet)

12. Have you received any of the following tests? **Date:**

□ Diagnostic x-rays □ CT (computed tomography) scan □ Electromyogram (EMG)
□ Discogram □ MRI (magnetic resonance imaging) □ Others _____

13. In general would you say your overall health right now is…

□ Excellent □ Very good □ Good □ Fair □ Poor

14. Medical history (Circle Yes or No)

Allergies	Y / N	Dizzy Spells	Y / N	MRSA	Y / N
Anemia	Y / N	Emphysema/Bronchitis	Y / N	Multiple Sclerosis	Y / N
Anxiety	Y / N	Fibromyalgia	Y / N	Muscular Disease	Y / N
Arthritis	Y / N	Fractures	Y / N	Osteoporosis	Y / N
Asthma	Y / N	Gallbladder problems	Y / N	Parkinson's	Y / N
Autoimmune Disorder	Y / N	Headaches	Y / N	Rheumatoid Arthritis	Y / N
Cancer	Y / N	Hearing Impairment	Y / N	Seizures	Y / N
Cardiac Conditions	Y / N	Hepatitis	Y / N	Smoking	Y / N
Cardiac Pacemaker	Y / N	High Cholesterol	Y / N	Speech Problems	Y / N
Chemical Dependency	Y / N	High/Low Blood Pressure	Y / N	Strokes	Y / N
Circulation Problems	Y / N	HIV / AIDS	Y / N	Thyroid Disease	Y / N
Currently Pregnant	Y / N	Incontinence	Y / N	Tuberculosis	Y / N
Depression	Y / N	Kidney Problems	Y / N	Vision Problems	Y / N
Diabetes	Y / N	Metal Implants	Y / N	Other:	Y / N

15. Fall History:

□ Injury as a result of fall in the past year: Yes / No When:

□ Two or more falls in the past year: Yes / No When:

16. Surgical History:(If additional space is needed please use the back of this sheet)

□ Date:____/_____/_____ □ Body region:

□ Surgery type:

17. Do you have any additional information that would be helpful in understanding your problem?

Patient signature: _____ **Date:** _____