Achieve Orthopedic Rehab Institute

DISCLAIMER FOR MEDICARE PATIENTS ONLY

Medicare allows $2,230.00 per calendar year- average visits will be 14-17 visits.

Medicare Part B 2023 deductible is $226.00 per calendar year.

If you qualify for the "KX Modifier" treatment can continue above and beyond this dollar amount when deemed medically necessary.

Your visits may be lower depending on your use of Physical and Speech therapy you may have received from other facilities.

Medicare covers 80%, should you carry a supplement plan, they typically cover the remaining 20%. (Depends on your policy)

If you have received or are still receiving home health physical therapy, your insurance will not cover outpatient's physical therapy. To ensure coverage, please confirm with your home health provider they have sent your discharge to Medicare.

Print Patient Name:_____

Patient Signature:_____Date:_____

Locations:

7055 South High Grove	Burr Ridge, IL 60527	P. 630.371.1623	F. 630.371.1546
60 E Delaware Pl Suite 1460	Chicago, IL 60611	P. 312.642.3963	F. 312.642.3966
1315 Macom Dr Suite 105	Naperville, IL 60564	P. 331.213.7247	F. 331.457.5749
9121 West 159th St Suite Suite D&E	Orland Hills, IL 60487	P. 708.403.1155	F. 708.403.1177
422 N. Northwest Hwy Suite 200	Park Ridge, IL 60068	P. 847.384.8511	F. 847.384.8513
760 Pasquinelli Dr Suite 304	Westmont, IL 60559	P. 630.568.3076	F. 630.568.3192
6300 Robert Kingery Hwy Suite 204	Willowbrook, IL 60527	P. 630.371.1623	F. 630.371.1546

ACHIEVE ORTHOPEDIC REHAB INSTITUTE

Patient Name:	Date of Birth
Patient Address	
Patient Phone:	Patient SSN:
Patient Email:	
Emergency Contact Name:	
Emergency Contact Phone:	
Primary & Secondary Insurance Name:	
Insurance Policy Holder Name:	Insurance Policy Holder DOB:
ONLY FOR WORKERS COMPENSATION	
Injury Date:	Claim Number:
WC Adjuster name:	Adjuster Phone#:
Employer Name:	State that injury happened:
Employer Address:	

Please Read and Initial the following	
I have informed Achieve Staff of any insurance coverage or changes that I am aware of.	**Initial**
I understand that as a courtesy Achieve Staff will be verifying my insurance benefits. However, I understand that a quote of benefits is not a guarantee of payment.	**Initial**
I understand that Co-Pays, Deductible and Co-Insurance specified by my insurance are my responsibility at the time of service. These fees are not negotiable.	**Initial**
I understand appointment cancellation and the No-Show policy includes failure to give 24 hours prior notice and will result in $75 fee. This fee can't be billed to your insurance company and will be your responsibility. This will be billed to your card on file.	**Initial**
I authorize Achieve Orthopedic Rehab to leave message/voicemail as needed	**Initial**

Print Patient Name:_____ Date:_____

Patient Signature:_____

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PATIENT CONSENT/AUTHORIZATION FORMS

o **CONSENT OF TREATMENT: I authorize Achieve Ortho Physical Therapist (s) to perform treatments including but not limited to Therapeutic Exercises, Pain treatment modalities (interferential, ultrasound, e-stimulation, ice/heat) and Manual Therapy.** o **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 anytime.**	**Initial**
o **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 release to my referral Physician and/or my insurance company any information required in the course of my examination or treatment which is necessary to process claims for services rendered.** o **I also authorize Achieve Orthopedic Rehab to discuss my medical condition with another person (spouse, care-taker, attorney, other)** **Please let us know whom you authorize: _____**	**Initial**
o **INSURANCE AUTHORIZATION: I request that payment of authorized benefits be made to Achieve Ortho Rehab on my behalf for any services provided to me.** o **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.**	**Initial**
o **CONSENT OF RELEASE AND USE OF CONFIDENTIAL INFORMATION: I have the right to examine and obtain a copy of my health records at any time. Should any Medical records be requested must be submitted in writing.**	**Initial**
o **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.**	**Initial**
o **I understand that this consent is valid until it is revoked by me. I understand that I may revoke at any time by giving written notice of my desire to do so to the Physical Therapist. I also understand that I won't be able to revoke in cases where PT has already relied on it to use disclose my health information.**	**Initial**
o **I understand that Achieve Ortho Rehab has reserved the right to change his or her privacy practices that are described in the notice. I also understand that a copy of any revise notice will be provided to me.**	**Initial**

IF THE PATIENT REFUSES TO INITIAL & SIGN THIS CONSENT FOR THE PURPOSE OF TREATMENT, ACHIEVE ORTHOPEDIC REHAB HAS THE RIGHT TO REFUSE CARE

Print Patient Name:_____**Date:**_____

Patient Signature:_____

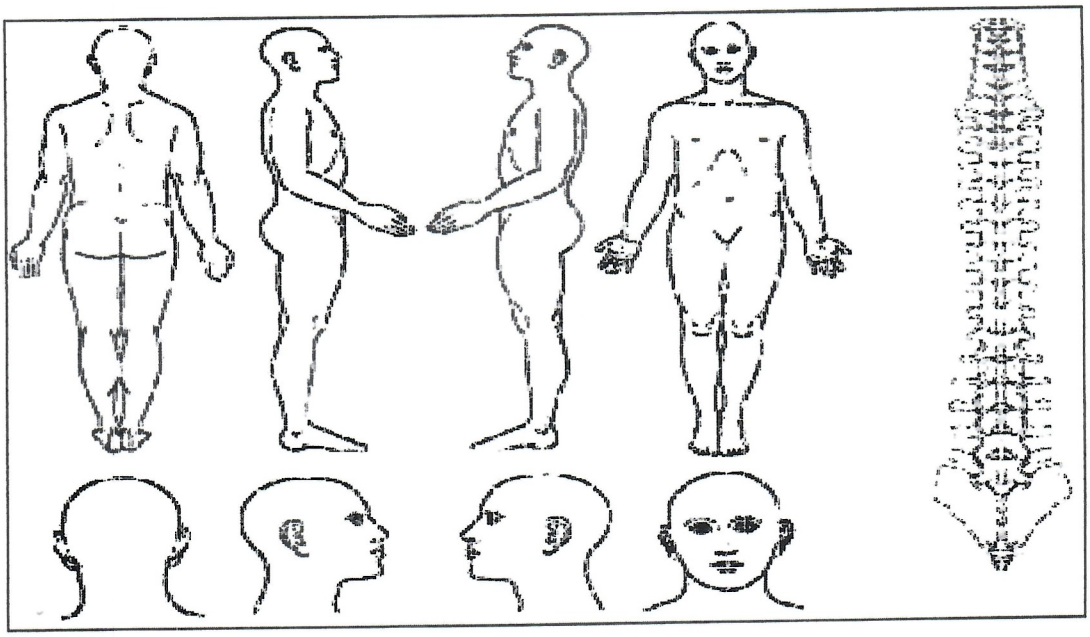
Achieve Orthopedic Rehab Institute

Patient Symptoms Report &Diagram

APTA American Physical Therapy Association The Science of Healing. The Art of Caring. CREDENTIALED RESIDENCY PROGRAM

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:** _____

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ACHIEVE ORTHOPEDIC REHAB INSTITUTE

A SURVEY FROM YOUR HEALTHCARE PROVIDER

Patient Name: _____ Today's Date: _____

Part of routine screening for your health includes reviewing mood and emotional concerns
PLEASE ANSWER IF YOU HAVE BEEN BOTHERED BY THE FOLLOWING PROBLEMS FOR THE LAST 2 WEEKS

	(0) Not at All	(1) Several days	(2) More than half days	(3) Nearly Every Day
Feeling down, depressed, irritable, hopeless				
Little interest or pleasure in doing things				
Trouble falling or staying asleep or sleeping too much				
Poor appetite, weight loss or overeating				
Feeling tired or having little energy				
Feeling bad about yourself or feeling that you are a failure				
Trouble concentrating on things like reading				
Moving or speaking slowly or the opposite				
Thoughts that you would be better off dead, or of hurting yourself in someway				
If you have any of the problems on this form, how difficult is for you to do work, take care of things or get along with other people. Please circle:	Not difficult	Somewhat difficult	Very difficult	Extremely difficult

ELDER ABUSE SUSPICION INDEX

Do you rely on people for bathing, dressing, shopping or meals?	Yes	No	Did not answer
Has anyone prevented you from getting food, clothes, meds, medical care or being with people you wanted?	Yes	No	Did not answer
Have you been upset because someone talked to you in a way that made you feel shamed or threaten?	Yes	No	Did not answer
Has anyone tried to force you to sign papers or to use your money against your will?	Yes	No	Did not answer
Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?	Yes	No	Did not answer
Doctor: Elder abuse <u>may</u> be associated with findings such as poor eye contact, withdrawn nature, malnourishment, hygiene issues, cuts, bruises, inappropriate clothing, or medication compliance issues. Did you notice any of this today or in the last 12 months?	Yes	No	Did not answer

The EASI was developed to raise a doctor's suspicious about elder abuse to a level at which it might be reasonable to propose a referral for further evaluation by social services adult protective services or equivalent.

Patient Signature: _____ **Date**_____