EMERY PHYSICAL THERAPY

2380 South Elmhurst Road #100
Mount Prospect, IL, 60056
Phone/Fax: 847-786-2014
info@emeryphysicaltherapy.com

PATIENT REGISTRATION

PERSONAL INFORMATION

NAME (LAST, FIRST, MIDDLE): _____ **DATE:** _____

ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

HOME PHONE (W/ AREA CODE): _____ **WORK PHONE:** _____ **CELL PHONE:** _____

CONTACT PREFERENCE: ☐ HOME ☐ WORK ☐ CELL **EMAIL ADDRESS:** _____

SOCIAL SECURITY NUMBER: _____ **DATE OF BIRTH:** _____ **SEX:** ☐ FEMALE ☐ MALE

EMPLOYER: _____ **EMPLOYER'S ADDRESS:** _____

REFERRING PHYSICIAN: _____ **SPECIALTY:** _____

EMERGENCY CONTACT: _____ **RELATIONSHIP:** _____

HOME PHONE (W/ AREA CODE): _____ **WORK PHONE:** _____ **CELL PHONE:** _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____

SUBSCRIBER'S NAME: _____ **DATE OF BIRTH:** _____

ID NUMBER: _____ **GROUP NUMBER:** _____

SECONDARY INSURANCE: _____

SUBSCRIBER'S NAME: _____ **DATE OF BIRTH:** _____

ID NUMBER: _____ **GROUP NUMBER:** _____

IF YOU HAD AN ACCIDENT PLEASE COMPLETE THIS SECTION

PRIMARY INSURANCE: _____

DATE OF ACCIDENT: _____ **HOW DID IT HAPPEN?** ☐ AUTO ☐ WORK ☐ OTHER **STATE IN WHICH INJURY OCCURRED:** _____

CLAIM NUMBER: _____ **INSURANCE COMPANY** (WORKER'S COMP. OR YOUR AUTO PIP): _____

ADDRESS: _____ **CLAIMS ADJUSTER:** _____ **PHONE NO.:** _____

I VERIFY THAT THE ABOVE INFORMATION IS ACCURATE (SIGNATURE): _____

PLEASE TELL US HOW YOU LEARNED OF OUR SERVICE OR WHOM WE CAN THANK

☐ Doctor recommendation	☐ Family/friend/co-worker recommendation	☐ Name: _____
☐ I was a former patient	☐ Found you on the internet	☐ Website: _____
☐ Clinic sign	☐ Publication/newspaper advertisement	☐ Publication: _____
☐ Health Insurance Company	☐ Saw you at an event	☐ Event: _____

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MEDICAL HISTORY

EXISTING OR RELEVANT PREVIOUS CONDITION

ALLERGIES	☐ YES ☐ NO	DIZZY SPELLS	☐ YES ☐ NO	MRSA	☐ YES ☐ NO
ANEMIA	☐ YES ☐ NO	EMPHYSEMA/BRONCHITIS	☐ YES ☐ NO	MULTIPLE SCLEROSIS	☐ YES ☐ NO
ANXIETY	☐ YES ☐ NO	FIBROMYALGIA	☐ YES ☐ NO	MUSCULAR DISEASE	☐ YES ☐ NO
ARTHRITIS	☐ YES ☐ NO	FRACTURES	☐ YES ☐ NO	OSTEOPOROSIS	☐ YES ☐ NO
ASTHMA	☐ YES ☐ NO	GALLBLADDER PROBLEMS	☐ YES ☐ NO	PARKINSON	☐ YES ☐ NO
AUTOIMMUNE DISORDER	☐ YES ☐ NO	HEADACHES	☐ YES ☐ NO	RHEUMATOID ARTHRITIS	☐ YES ☐ NO
CANCER	☐ YES ☐ NO	HEARING IMPAIRMENT	☐ YES ☐ NO	SEIZURES	☐ YES ☐ NO
CARDIAC CONDITIONS	☐ YES ☐ NO	HEPATITIS	☐ YES ☐ NO	SMOKING	☐ YES ☐ NO
CARDIAC PACEMAKER	☐ YES ☐ NO	HIGH CHOLESTEROL	☐ YES ☐ NO	SPEECH PROBLEMS	☐ YES ☐ NO
CHEMICAL DEPENDENCY	☐ YES ☐ NO	HIGH/LOW BLOOD PRESSURE	☐ YES ☐ NO	STROKES	☐ YES ☐ NO
CIRCULATION PROBLEMS	☐ YES ☐ NO	HIV/AIDS	☐ YES ☐ NO	THYROID DISEASE	☐ YES ☐ NO
CURRENTLY PREGNANT	☐ YES ☐ NO	INCONTINENCE	☐ YES ☐ NO	TUBERCULOSIS	☐ YES ☐ NO
DEPRESSION	☐ YES ☐ NO	KIDNEY PROBLEMS	☐ YES ☐ NO	VISION PROBLEMS	☐ YES ☐ NO
DIABETES	☐ YES ☐ NO	METAL IMPLANTS	☐ YES ☐ NO		

DESCRIBE ANY OTHER CONDITIONS

IF "YES" TO ANY OF THE ABOVE, PLEASE EXPLAIN AND GIVE APPROXIMATE DATES. DESCRIBE ANY OTHER CONDITIONS

FALL HISTORY

☐ **INJURY AS A RESULT OF A FALL IN THE PAST YEAR?** ☐ **TWO OR MORE FALLS IN THE LAST YEAR** ☐ **AT RISK FOR FALLS**

SURGICAL HISTORY

BODY REGION: _____ **SURGERY TYPE:** _____ **DATE:** _____

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BODY REGION: _____ **SURGERY TYPE:** _____ **DATE:** _____

CURRENT MEDICATION

DRUG: _____ **DOSAGE:** _____ **FREQ.:** _____ **ROUTE:** _____ **REASON TAKING:** _____

DRUG: _____ **DOSAGE:** _____ **FREQ.:** _____ **ROUTE:** _____ **REASON TAKING:** _____

DRUG: _____ **DOSAGE:** _____ **FREQ.:** _____ **ROUTE:** _____ **REASON TAKING:** _____

DRUG: _____ **DOSAGE:** _____ **FREQ.:** _____ **ROUTE:** _____ **REASON TAKING:** _____

☐ **CURRENTLY NOT TAKING ANY MEDICATIONS**

EMERY PHYSICAL THERAPY - CONSENT FOR TREATMENT

1. **CONSENT FOR TREATMENT:** I hereby consent to, and authorize my physical therapist, occupational therapist and other health care professionals and assistants who may be involved in my care, to provide care and treatment prescribed by my physician and/or considered necessary or advisable by my physician, physical therapist, occupational therapist or other healthcare professionals. I understand that a physical therapy diagnosis is not a medical diagnosis by a physician. I understand that my treatment may include techniques that can result in bruising, reddening of the skin, soreness after treatment and hematoma, including, without limitation, spinal manipulation, dry needling, myofascial decompression and blood flow restriction, Instrument assisted soft tissue mobilization, Video Analysis. I understand that it is my responsibility to inform my physical therapist, or other health care professional if I experience any discomfort or pain during any treatment or if I have other unresolved concerns before my treatment. I understand that response to physical therapy intervention varies from person to person and it is possible that treatment may result in aggravation of existing symptoms or may cause pain or injury. Emery Physical Therapy (Emery PT) complies with applicable civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

2. **APPOINTMENT ATTENDANCE AGREEMENT:** I understand the importance of attending therapy consistently, scheduling appointments in advance and arriving promptly for my appointment. I acknowledge that I may be rescheduled if I arrive more than 15 minutes late for my scheduled appointment. I understand and acknowledge that appointment times given one week may not be available in subsequent weeks. I agree to provide at least 24 hours' notice when I need to cancel or reschedule an appointment and I understand that cancellation of, or failing to keep, an appointment with less than 24 hours' notice more than 3x may result in a cancel/no show fee of $30.

3. **RESPONSIBILITY FOR PAYMENT:** All co-payments and self –pay services are due at the time of service. I acknowledge that in consideration of the services provided to me by Emery PT, I am financially responsible for payment of my bill. I acknowledge that it is my responsibility to provide Emery PT with my current insurance information and to familiarize myself with my insurance plan and its policies. Any questions I have regarding my health insurance coverage or benefit levels should be directed to my health plan. My health insurance plan may provide that all or a portion of the charges and balance will remain my personal responsibility, such as my deductible, co-payment, co-insurance or charges not covered or denied by my health insurance, Medicare, or other programs for which I am eligible. I agree to pay any such amounts which are my responsibility. I understand that Emery PT will bill my personal insurance carrier as a courtesy, but that I am ultimately responsible for any amounts owed. If formal collection procedures become necessary, I am responsible for any additional costs incurred as a result of such collection procedures. If I pay any amount with a check, I hereby authorize Emery PT to use the information from the check to process a one-time Electronic Funds Transfer (EFT/ACH) or a draft drawn from my account. I understand that if my payment is processed as an EFT, funds may be withdrawn from my account as soon as the same day and I will not receive my check back from my financial institution. Please note that refusal to sign this form does not change responsibility for payment in any way.

4. **ASSIGNMENT OF BENEFITS**: I hereby assign to Emery PT all my rights and claims for reimbursement under my health insurance policy. I agree to cooperate with Emery PT and to provide such information as is needed to establish my eligibility for such benefits.

5. **ACCESS TO AND RELEASE OF HEALTH INFORMATION:** I understand that Emery PT may document medical and other information related to my treatment in electronic and other forms and that such information will be used in the course of my treatment, for payment purposes and to support those who are caring for me. I authorize my clinician(s) and Emery PT's administrative staff to contact other healthcare professionals that may have information related to my prior and current health conditions and treatment. I acknowledge that I have received Emery PT's Notice of Privacy Practices and/or have seen it posted at the front desk and that it outlines how my health information may be used and disclosed and how I may gain access to and control my health information. By my signature below, I certify that I have read, understand, and fully agree to each of the statements in this document and sign below freely and voluntarily.

_____

Printed Name of Patient **Signature of Patient or Legally Responsible Person** **Date**

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EMERY PHYSICAL THERAPY HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. THIS NOTICE IS POSTED ON THE FRONT DESK IN OUR OFFICE

PLEASE REVIEW IT CAREFULLY

Emery Physical Therapy is committed to maintaining and protecting the confidentiality of our patients' medical, personal, and sensitive information. We are required by federal and state law to protect the privacy of your individual identifiable health information and other personal information and send you this Notice about our policies, safeguards, and practices. When we use or disclose your confidential information, we are bound by the terms of this Notice or our revised notices, if we revise it.

USES AND DISCLOSURES

TREATMENT: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example results of tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

PAYMENT: Your health information may be used to seek payment from your health plan or from other sources of coverage such an automobile insurer, or worker's compensation carrier. For example, your insurer may request and receive information on dates of service, the type of services provided, and the medical condition being treated.

HEALTH CARE OPERATION: Your health information may be used as necessary to support the day-to-day activities and management of Emery Physical Therapy. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality. Law Enforcement: Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

LAWSUITS AND DISPUTES: Your health information may be disclosed in response to a court or administrative order. For example, if you are involved in a lawsuit or dispute and Emery Physical Therapy is served with a subpoena, warrant, summons, or other lawful process this office may be required by law to disclose your health information.

PUBLIC HEALTH REPORTING: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state Public Health Department.

INFORMATION ABOUT TREATMENTS: Your health information may be used to send your information on the treatment and management of your medical condition that you may find to be of interest. We may also send your information describing other health related goods and services that we believe may interest you.

APPOINTMENT REMINDERS: Your health information may be used by our staff to contact you regarding appointment openings and reminders. If you have any concerns about us leaving messages or information pertaining to appointment dates and times with other household members, please let us know. No confidential patient information will be left by phone.

OTHER USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION: Disclosure of your health information or its use for any purpose other than those listed above requires your specific authorization. If you change your mind after authorizing a use or disclosure of your information you may submit in written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified Emery Physical Therapy.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights under the federal privacy standards regarding the health information that we maintain about you. These rights are as follows:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend and submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice.

RIGHTS TO REVISE PRIVACY PRACTICES: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policy and practices may be required by changes in federal and/or state laws and regulations. Whatever the reason for these revisions we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

REQUEST TO INSPECT PROTECTED HEALTH INFORMATION: As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing to our office.

COMPLAINTS: If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter discussing your concerns to:

Emery Physical Therapy Attn: Office Manager
2380 South Elmhurst Road, Ste. 100
Mount Prospect, IL 60056
847-786-2014

If you feel that your privacy rights have been violated, you may file a complaint with our office or the Secretary of the Department of Health and Human Services. You will not be penalized or otherwise retaliated against for filing a complaint.

I ACKNOWLEDGE that I have received a copy of Emery Physical Therapy's notice of privacy practices. I understand that this information describes how Emery Physical Therapy may disclose and use my protected health information. I understand that Emery Physical Therapy is a separate and distinct practice from the Medical Center.

Patient's Name (print) _____ **Date** _____

Patient's Signature _____

This notice is effective on or after August 7th, 2017

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NAME (LAST, FIRST, MIDDLE): **AGE:** **HEIGHT:** **WEIGHT:** **OCCUPATION, SPORTS, HOBBIES:**

WHAT IS YOUR MAIN COMPLAINT? (PAIN, STIFFNESS, WEAKNESS, ETC.) **WHAT DATE DID THE PROBLEM START?**

WAS THIS THE RESULT OF AN ACCIDENT/INJURY? ☐ YES ☐ NO

IS THIS A WORK RELATED INJURY? ☐ YES ☐ NO

HAVE YOU EVER HAD THIS PROBLEM BEFORE? ☐ YES ☐ NO WHEN?

HOW DID THE PROBLEM START OR WERE YOU INJURED? (PLEASE DESCRIBE)

WHICH DOCTOR(S) DID YOU SEE? **WHEN?**

LIST ALL PRESENT MEDICATIONS:

HAVE YOU HAD ANY TESTS? (X-RAYS, MRIs) ☐ YES ☐ NO **WHEN?** **RESULTS?**

DID YOU HAVE SURGERY? ☐ YES ☐ NO **WHEN?** **TYPE OF SURGERY?**

PAIN RATING (0-10) 0 AS NO PAIN, 10 AS INTOLERABLE **NOW:** **WORST:** **BEST:**

WHERE IS THE PAIN OR SYMPTOMS? (EX. WHAT PART(S) OF YOUR BODY?)

DESCRIBE THE PAIN OR SYMPTOMS? (EX. ACHY, SHARP, SORE, ETC.)

PAIN OR SYMPTOMS ARE AGGRAVATED BY WHAT KINDS OF MOVEMENTS, ACTIVITIES, POSITIONS, ETC.:

PAIN OR SYMPTOMS ARE RELIEVED BY WHAT KINDS OF TREATMENTS, MOVEMENTS, ACTIVITIES, POSITIONS, ETC.:

PERSISTENCE? ☐ CONSTANT ☐ COMES AND GOES

PAIN IS WORSE IN ☐ AM ☐ PM ☐ BOTH

SINCE THE PAIN STARTED, IS IT GETTING? ☐ BETTER ☐ WORSE ☐ STAYING SAME

DO YOU EXPERIENCE ANY OF THE FOLLOWING? ☐ PINS & NEEDLES ☐ NUMBNESS ☐ TINGLING

WHERE?

DO YOU EXPERIENCE ANY OF THE FOLLOWING?

☐ SWELLING ☐ CLICKING ☐ CATCHING ☐ LOCKING ☐ BUCKLING ☐ GRATING ☐ HEADACHES ☐ FEVER ☐ DIZZINESS ☐ FALLS

HAVE YOU TRIED ANY OTHER TREATMENTS: **WHAT ARE YOUR GOALS IN THERAPY?**

ANY OTHER DETAILS THAT YOU BELIEVE IS PERTINENT TO THIS PROBLEM:

CELL PHONE: **EMAIL:**