

Lake County Physical Therapy LLC

301 E. Rollins Rd, Round Lake Beach, IL 60073 847-201-7612
1047 E Lake Cook Rd, Wheeling, IL 60090 847-229-0140
351 S Greenleaf St, Suite "E", Park City, IL 60085 847-219-6278
100 N. Atkinson Rd, Suite 207, Grayslake, IL 60030 847-543-7604

Dear Valued Client:

Thank you for choosing **Lake County Physical Therapy LLC** for your physical therapy needs. We appreciate your business and look forward to exceeding your expectations. If you have any questions, please do not hesitate to ask the therapist or staff. We look forward to partnering with you on your road to full recovery.

The following pages are for you to fill out legibly and accurately. The first page is a signature page that you have seen a copy of the HIPPA Notice of Privacy Practice. If you wish to have a written copy, please ask our staff. The second page is for billing and demographic information. The third page is a questionnaire regarding your medical history. And last is a page for you to map your area(s) of pain on the drawing.

Please inform us when you have an appointment with your referring physician so we can update them on your progress.

It is very important that you maintain your scheduled appointments and not stop coming when you start to feel a little better. Discontinuing the therapy could hurt you in the long run. If you need to reschedule your appointment, please give us at least 24 hours notice or you may be subject to a no-show/cancellation charge of \$35.00.

Co-payments are expected at the time of service. You will be advised of your co-pay after we verify your insurance. We understand that co-pays can be significant. If you cannot make full payment for your co-pays at the time of service, please contact our billing department to make arrangements.

We encourage you to contact your insurance company to verify your coverage and benefits.

We pledge to give you prompt, efficient, courteous service rendered by a licensed Physical Therapist. We welcome your comments and suggestions and want to take this opportunity to welcome you to your first therapy session.

Sincerely,
The Staff of Lake County Physical Therapy

→ Is your condition/injury the result of a motor vehicle accident / a work related accident / or any other accident?.....Yes / No If yes, date:_____

I _____, (PRINT NAME) have read this page and agree with the requirements stated and acknowledge responsibility for the above items.

Signature _____ Date

Allow Us To Exceed Your Highest Expectations!



Lake County Physical Therapy LLC

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____,
have received the Notice of Privacy Practices from Lake County Physical Therapy, LLC.

Signature Date

In lieu of patient signature, I _____,
a staff member of Lake County Physical Therapy, state that _____
has been given our current Notice of Privacy Practices.

Signature Date

Allow Us To Exceed Your Highest Expectations!

LAKE COUNTY PHYSICAL THERAPY, LLC

First Name _____ Last Name _____

Date of Birth _____ Social Security# _____

Email Address: _____
(This is needed so we can send you newsletters, your therapy information or updates. **This will never be sold or shared!**)

Address _____

City _____ State _____ Zip _____

Home Phone# _____ Work Phone # _____

Cell Phone# _____ Male Female

Single Married Divorced Widowed Separated

Referring Physician _____ Physician Phone# _____

Primary Care Physician _____ P.C.P. Phone# _____

Onset Date _____ Physician Appointment _____

If you have more than one insurance carrier, please indicate which is primary and which is secondary. **IT IS YOUR RESPONSIBILITY TO INFORM US IF YOUR COVERAGE IS CONTINGENT UPON A SECOND OPINION OR PRIOR APPROVAL OF YOUR INSURANCE CARRIER.** We will make a photocopy of your insurance cards so please have them available.

Primary Insurance _____ Secondary Insurance _____

Card Holder's Name if Other than Self _____ Relationship _____

Card Holder's SS# _____ Card Holder Birth Date _____

Auto Workman's Comp Liability **Claim #** _____ Third Party Own Auto Ins.

Case Manager Name _____ Phone# _____

Case Manager Fax# _____

Insurance Company
Name/Address _____

Work Company
Name/Address _____

I hereby authorize Lake County Physical Therapy LLC to perform treatments and procedures that they consider necessary for my benefit, upon consultation with my representative or me. I understand that I am financially responsible for any balance not covered by insurance. *I understand that there may be a \$35.00 no show/cancellation charge if I fail to show up or call 24 hours in advance.*

Medicare Patient's Certification, Authorization to Release Information, Payment Request

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or any Medicare claim. I request that payment of the authorized benefits be made to Lake County Physical Therapy LLC on my behalf.

Insurance Patient's Certification, Authorization to Release Information, Payment Request.

Insurance Patient's Certification, Authorization to Release Information, Payment Request

I certify that the information given by me in applying for payment under the provisions of my medical insurance is correct. I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits to Lake County Physical Therapy LLC.

Patient Signature or Authorized Representative _____ Date _____

LAKE COUNTY PHYSICAL THERAPY LLC

Name _____ Age _____ Occupation _____

MEDICAL HISTORY QUESTIONNAIRE

Are you working now?.....Yes / No If no, since: _____

Do you have a cardiac problem?.....Yes / No

Do you have a cardiac pacemaker?.....Yes / No

Do you have a metal implant?.....Yes / No

Do you have any joint replacements?.....Yes / No

Do you have a history of cancer?.....Yes / No

Do you have high blood pressure?.....Yes / No

Do you have a history of high cholesterol?.....Yes / No

Do you have diabetes?.....Yes / No

Do you have a history of seizures?.....Yes / No

Do you smoke?.....Yes / No

Any recent X-Rays/MRI/CT Scan?.....Yes / No If yes, when? _____

Have you had Home Health this year?.....Yes / No If yes, when? _____

Is a Nurse currently seeing you at home? Yes / No

FEMALES: Are you pregnant?.....Yes / No If yes, weeks: _____

Have you ever had Physical, Occupational or
Speech Therapy before.....Yes / No

If yes, please describe: _____

Your present Medications: _____

Allergies / Reactions: _____

Pertinent Medical History / Surgeries: _____

What is your major complaint? _____

How and when did this start? _____

Have you ever had anything similar before?.....Yes / No

Do you have any pain?.....Yes / No

If yes, is your pain a: Throb Twinge Burning Other _____

Where is your pain located? _____

What makes your pain worse? (ie sitting, standing, etc): _____

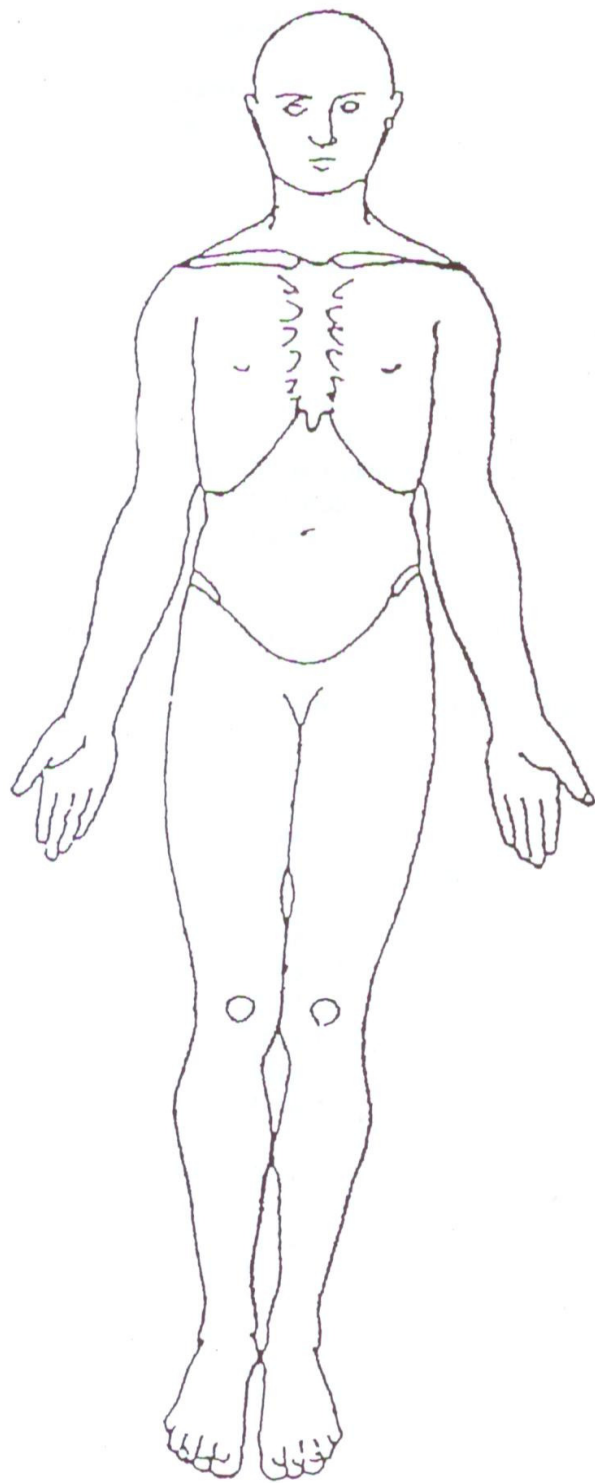
Rate your pain at this time: 0 1 2 3 4 5 6 7 8 9 10 (0-1 mild / 10 severe)

Best it has been since injury: 0 1 2 3 4 5 6 7 8 9 10 (0-1 mild / 10 severe)

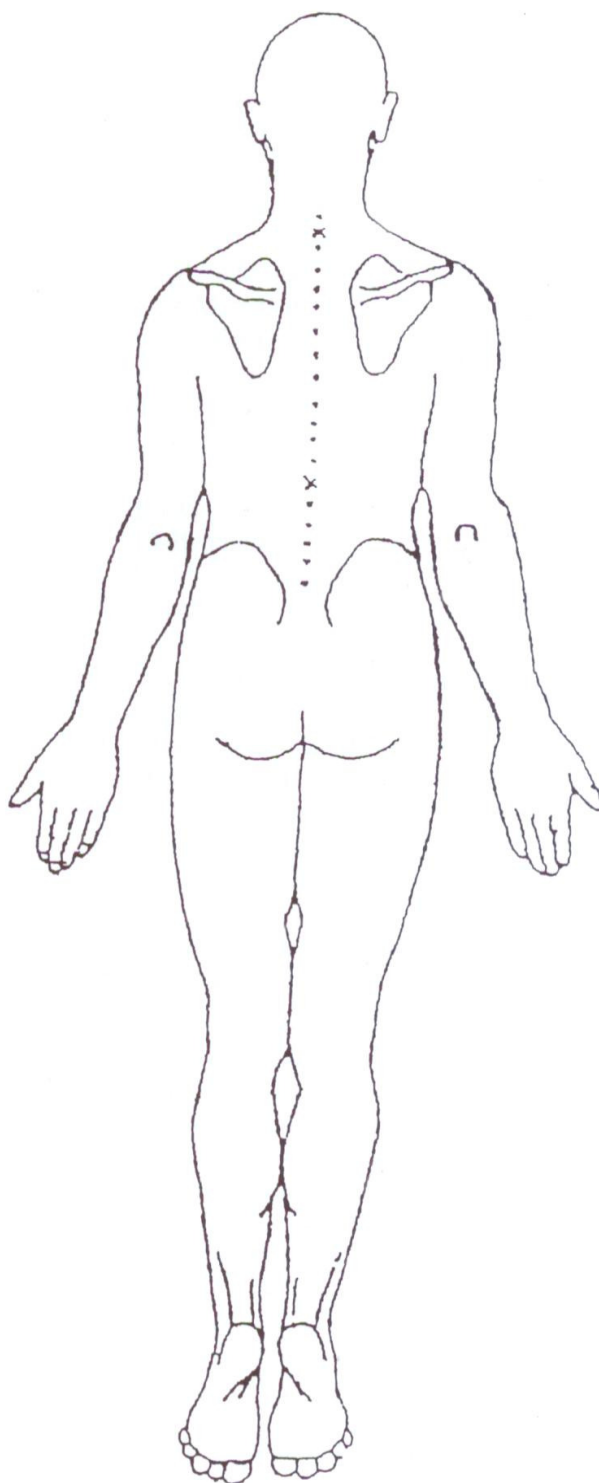
Worst it has ever been: 0 1 2 3 4 5 6 7 8 9 10 (0-1 mild / 10 severe)

What are you unable to do because of your pain / problem? _____

Please shade in the area of the diagram below indicating where you have pain.



RIGHT LEFT



LEFT RIGHT