

Stay Fit Physical Therapy Core Wellness, Inc.

NEW PATIENT REGISTRATION						
THERAPIST			APPOINTMENT DATE:			
LAST NAME	FIRST NAME	MI	DOB	SOCIAL SECURITY	SEX	
MARITAL STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		Have you been treated at Stay Fit Physical Therapy clinic before? If yes, when?		EMAIL ADDRESS		
EMPLOYMENT STATUS Employed <input type="checkbox"/> Student: FT <input type="checkbox"/> PT <input type="checkbox"/>		EMPLOYER/SCHOOL NAME		TITLE/POSITION		
HOME ADDRESS		CITY	STATE	ZIP CODE	DAYTIME PHONE	CELL PHONE
REFERRING PHYSICIAN INFORMATION						
LAST NAME		FIRST NAME		ADDRESS		PHONE
REASON FOR YOUR VISIT TODAY						
IS THIS AN INJURY RELATED CONDITION? IF SO, PLEASE INDICATE REASON: (PLEASE CIRCLE)						
JOB RELATED		CAR ACCIDENT		HOME ACCIDENT		OTHER: _____
PLEASE INDICATE THE DATE OF YOUR INJURY: / /			DATE OF YOUR FIRST SYMPTOM: / /			
NAME OF INSURANCE ADJUSTER			PHONE			
PLEASE DESCRIBE YOUR INJURY/ACCIDENT:						
PRIMARY INSURANCE COMPANY INFORMATION						
PRIMARY INSURANCE COMPANY NAME		IDENTIFICATION NUMBER		GROUP NUMBER		
ADDRESS OF PRIMARY INSURANCE		CITY		STATE	ZIP CODE	
POLICYHOLDER NAME (IF DIFFERENT FROM PATIENT)		PHONE NUMBER OF POLICY HOLDER		RELATIONSHIP TO PATIENT		
SOCIAL SECURITY (POLICYHOLDER'S)		DOB (POLICYHOLDER'S)		RELATIONSHIP TO PATIENT		
EMPLOYER (POLICYHOLDER'S)			HOME PHONE		CELL PHONE	
SECONDARY INSURANCE COMPANY INFORMATION						
SECONDARY INSURANCE COMPANY NAME		IDENTIFICATION NUMBER		GROUP NUMBER		
ADDRESS OF SECONDARY INSURANCE		CITY		STATE	ZIP CODE	
POLICYHOLDER NAME (IF DIFFERENT FROM PATIENT)		PHONE NUMBER OF POLICY HOLDER		RELATIONSHIP TO PATIENT		
SOCIAL SECURITY (POLICYHOLDER'S)		PHONE (POLICYHOLDER'S)		RELATIONSHIP TO PATIENT		
EMPLOYER (POLICYHOLDER'S)			WORK PHONE (POLICYHOLDER'S)			

Stay Fit Physical Therapy Core Wellness, Inc.

NOTICE OF PRIVACY PRACTICES EFFECTIVE JANUARY 2010

OUR COMMITMENT AT STAY FIT PHYSICAL THERAPY & CORE WELLNESS, INC. IS TO SERVE OUR CUSTOMERS WITH PROFESSIONALISM AND CARE, BEING SURE AT ALL TIMES TO PROTECT THE PRIVACY AND SECURITY OF ALL PROTECTED HEALTH INFORMATION.

DURING THE COURSE OF SERVING YOU, IT MAY BE NECESSARY TO SHARE INFORMATION WITH OTHER HEALTH CARE PROVIDERS OR BUSINESS ASSOCIATES. THE FOLLOWING ARE EXAMPLES OF INSTANCES WHERE INFORMATION MAY SHARED:

- FOR PAYMENT PURPOSES, WE MAY EMPLOY A BILLING SERVICE.
- DURING TREATMENT, WE MAY FIND IT NECESSARY TO CONTACT YOUR PHYSICIANS.

AT STAY FIT PHYSICAL THERAPY & CORE WELLNESS INC., WE ARE COMMITTED TO OBEYING ALL FEDERAL, STATE, AND LOCAL LAWS AND REGULATIONS REGARDING PRIVACY PRACTICES. IF ANY OTHER USES OR DISCLOSURES OTHER THAN THE ONES LISTED ABOVE ARE NEEDED, INFORMATION WILL ONLY BE RELEASED WITH THE WRITTEN AUTHORIZATION OF THE INDIVIDUAL IN QUESTION. THIS WRITTEN AUTHORIZATION MAY BE REVOKED AT ANY TIME BY THE INDIVIDUAL, AS PROVIDED BY LAW.

WE ARE VIGILANT IN PROTECTING PATIENT CONFIDENTIALITY. NO INFORMATION REGARDING YOU IS SHARED OR DISTRIBUTED WITH ANY ORGANIZATION WITHOUT YOUR SIGNED AUTHORIZATION.

IF YOU HAVE ANY QUESTIONS OR COMMENTS REGARDING YOUR PROTECTED HEALTH INFORMATION, FEEL FREE TO CONTACT OUR BUSINESS MANAGER AT 847-255-2348.

I HAVE READ, UNDERSTAND, AND AGREE WITH THE ABOVE NOTICE OF PRIVACY PRACTICES, AND AUTHORIZE THE RELEASE OF MY MEDICAL INFORMATION TO THE ABOVE MENTIONED PARTIES.

SIGNATURE

DATE

Stay Fit Physical Therapy Core Wellness, Inc.

FINANCIAL POLICY

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY THE INSURANCE COMPANY(S) LISTED ON THIS REGISTRATION. I UNDERSTAND THAT VERIFICATION OF BENEFITS IS NOT A GUARANTEE OF PAYMENT OR A GUARANTEE OF PAYMENT ACCORDING TO THE ACTUAL BENEFITS QUOTED. SHOULD I NEED DETAILED INFORMATION ABOUT MY COVERAGE, I WILL CONTACT MY INSURANCE COMPANY DIRECTLY. IN THE EVENT MY ACCOUNT BECOMES DELINQUENT, AND IS THEREFORE IN DEFAULT OF PAYMENT, I ACCEPT RESPONSIBILITY FOR THE PRINCIPLE AMOUNT OWING AS WELL AS ALL REASONABLE COSTS AND ADDITIONAL LEGAL FEES ASSOCIATED WITH THE RECOVERY OF THIS DEBT.

DENIAL OF PAYMENT

* SHOULD MY INSURANCE COMPANY ISSUE A DENIAL OF PAYMENT, AND I CHOOSE TO CONTINUE WITH STAY FIT PHYSICAL THERAPY & CORE WELLNESS, INC., I AGREE TO MAKE PAYMENTS AT THE TIME ALL SUBSEQUENT SERVICES ARE PROVIDED.

THIRD PARTY BILLING

* THIRD PARTY BILLING I UNDERSTAND THAT THIRD PARTY BILLING TO ATTORNEYS OR THIRD PARTY MOTOR VEHICLE CARRIERS IS AVAILABLE, BUT I AM ULTIMATELY RESPONSIBLE FOR UNPAID BILLS OVER 1 YEAR OLD.

FINANCIAL RESPONSIBILITY

I AGREE TO BE RESPONSIBLE FOR INSURANCE DEDUCTIBLES, CO-PAYMENTS, CO-INSURANCE, AND SUPPLY FEES AT THE TIME SERVICES ARE RENDERED.

INTEREST

* INTEREST MAY BE CHARGED AT A RATE OF 1.5% PER MONTH (18% ANNUALLY) FOR UNPAID BALANCES OVER 30 DAYS OLD.

RETURNED CHECKS

* I UNDERSTAND THAT A FEE OF \$40.00 WILL BE ASSESSED FOR ANY CHECK RETURNED UNPAID.

PAYMENT OPTIONS

* WE ACCEPT CASH, CHECKS, VISA, MASTERCARD AND DISCOVER. (NO AMERICAN EXPRESS)

ASSIGNMENT OF BENEFITS / AUTHORIZATION TO RELEASE MEDICAL INFORMATION / CONSENT OF TREATMENT

I HEREBY ASSIGN ALL MEDICAL BENEFITS TO WHICH I AM ENTITLED TO STAY FIT PHYSICAL THERAPY & CORE WELLNESS, INC. I HEREBY AUTHORIZE STAY FIT PHYSICAL THERAPY & CORE WELLNESS, INC. TO RELEASE ANY INFORMATION NECESSARY TO SECURE THE PAYMENT OF SAID BENEFITS.

CANCELLATION / NO SHOW POLICY

A TWENTY FOUR HOUR NOTICE IS APPRECIATED FOR ALL CANCELLATIONS. IN THE EVENT OF AN UNFORSEEN EMERGENCY. PLEASE CALL PRIOR TO 8:00 AM THE DAY OF APPOINTMENTS TO AVOID PENALTY. WHEN POSSIBLE, A 24 HOUR NOTICE IS APPRECIATED.

CANCELLATIONS LATER THAN 8:00 AM THE DAY OF AN APPOINTMENT WILL RESULT IN THE FOLLOWING:

- * 1ST TIME: A REMINDER WILL BE GIVEN
- * 2ND+ TIME: A \$50 FEE WILL BE CHARGED TO YOUR ACCOUNT

NO SHOWS

- * 1ST TIME: A \$50 FEE WILL BE CHARGED TO YOUR ACCOUNT
- * 2ND+ TIME: \$120 FEE WILL BE CHARGED TO YOUR ACCOUNT

IF YOUR INJURY IS WORK RELATED, THE SAME POLICY APPLIES. AFTER THE THIRD CANCELLATION/NO SHOW, YOUR CASE MANAGER OR CLAIMS ADJUSTER WILL BE NOTIFIED OF YOUR LACK OF ATTENDANCE, AND THE WORKERS COMPENSATION INSURANCE WILL BE CHARGED THE FULL AMOUNT OF YOUR VISIT.

I HAVE READ, UNDERSTAND, AND AGREE WITH STAY FIT PHYSICAL THERAPY & CORE WELLNESS, INC.'S FINANCIAL, ASSIGNMENT OF BENEFITS/AUTHORIZATION TO RELEASE MEDICAL INFORMATION/CONSENT OF TREATMENT, AND CANCELLATION POLICIES.

SIGNATURE

DATE

Stay Fit Physical Therapy Core Wellness, Inc.

HEALTH QUESTIONNAIRE				
HEIGHT:	WEIGHT:	<input type="checkbox"/> RIGHT HANDED	<input type="checkbox"/> LEFT HANDED	
EDUCATION: <input type="checkbox"/> GRADE SCHOOL <input type="checkbox"/> HIGH SCHOOL <input type="checkbox"/> COLLEGE <input type="checkbox"/> GRAD SCHOOL				
TYPE OF INJURY: <input type="checkbox"/> WORK RELATED <input type="checkbox"/> SPORTS <input type="checkbox"/> MVA <input type="checkbox"/> OTHER				
DATE OF INJURY / ACCIDENT				
PLEASE DESCRIBE HOW YOU WERE INJURED OR WHAT PROMPTED YOU TO BE REFERRED FOR PHYSICAL THERAPY:				
ARE YOU PRESENTLY WORKING? <input type="checkbox"/> YES <input type="checkbox"/> NO HOURS PER WEEK ____				
<input type="checkbox"/> REGULAR DUTY <input type="checkbox"/> LIGHT DUTY				
JOB / WORKSTATION DESCRIPTION:				
HOBBIES:				
HAVE YOU RECEIVED PHYSICAL THERAPY IN THE PAST? IF SO, WHEN, WHERE AND WHY?				
WHAT HAVE YOU DONE TO IMPROVE YOUR PRESENT PROBLEM?				
PLEASE LIST CURRENT MEDICATION:				
ADDITIONAL INFORMATION (PLEASE LIST ALLERGIES (E.G.LATEX), LIMITATIONS, INJURIES, SURGERIES,				
METAL IMPLANTS FROM SURGERIES:				
IN CASE OF EMERGENCY				
LAST NAME		FIRST NAME		MI
ADDRESS		CITY	STATE	ZIP CODE
HOME PHONE		DAYTIME PHONE		CELL PHONE
RELATIONSHIP		EMAIL ADDRESS		

Stay Fit Physical Therapy Core Wellness, Inc.

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS OR PROBLEMS? PLEASE INDICATE "C" FOR CURRENT PROBLEMS OR "P" FOR PAST PROBLEMS:

- | | | |
|--------------------------------------------------|------------------------------------------------------|------------------------------------------|
| <input type="checkbox"/> DIZZINESS | <input type="checkbox"/> LOSS OF APPETITE | <input type="checkbox"/> STROKE |
| <input type="checkbox"/> HIATAL HERNIAS | <input type="checkbox"/> FAINTING SPELLS | <input type="checkbox"/> BONE FRACTURE |
| <input type="checkbox"/> GLAUCOMA | <input type="checkbox"/> FREQUENT HEADACHES | <input type="checkbox"/> CHEST PAIN |
| <input type="checkbox"/> LEG PAIN | <input type="checkbox"/> HEART ROBLEMS/PACEMAKER | <input type="checkbox"/> ARTHRITIS |
| <input type="checkbox"/> CONVULSING/SEIZURE | <input type="checkbox"/> INFECTIONS | <input type="checkbox"/> CANCER |
| <input type="checkbox"/> INFLUENZA | <input type="checkbox"/> DIABETES | <input type="checkbox"/> OSTEOPOROSIS |
| <input type="checkbox"/> SLEEPING DIFFICULTIES | <input type="checkbox"/> THYROID DISEASE | <input type="checkbox"/> NIGHT SWEATS |
| <input type="checkbox"/> JOINT INJURY | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> EPILEPSY |
| <input type="checkbox"/> RECENT WEIGHT LOSS/GAIN | <input type="checkbox"/> RECURRING BACK PAIN | <input type="checkbox"/> MUSCLE WEAKNESS |
| <input type="checkbox"/> SHORTNESS OF BREATH | <input type="checkbox"/> NUMBNESS/TINGLING SENSATION | |
| __ ON EXERTION | __ ARM(S) __ HAND(S) | |
| __ LYING FLAT | __ LEG(S) __ FOOT/FEET | |

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING CONDITIONS OR SITUATIONS AS A RESULT OF YOUR INJURY OR PHYSICAL CONDITON? PLEASE MARK ALL THAT APPLY:

- | | |
|---------------------------------------------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> UNABLE TO PARTICIPATE IN NORMAL HOBBIES/INTERESTS | <input type="checkbox"/> EXCESSIVE MOODINESS |
| <input type="checkbox"/> LOSS OF JOB __ PERMANENT __ TEMPORARY | <input type="checkbox"/> DEPRESSION |
| <input type="checkbox"/> LACK OF EMOTIONAL SUPPORT/CONFLICT WITH FAMILY/FRIENDS | <input type="checkbox"/> NERVOUSNESS |
| <input type="checkbox"/> SIGNIFICANT STRESS: __ HOME __ WORK __ OTHER | <input type="checkbox"/> FORGETFULNESS |
| <input type="checkbox"/> DIFFICULTY WITH DAILY ACTIVITIES | <input type="checkbox"/> GRIEF DUE TO FAMILY DEATH |
| <input type="checkbox"/> DIFFICULTY WITH SELF CARE | <input type="checkbox"/> TRANSPORTATION PROBLEMS |
| <input type="checkbox"/> DIFFICULTY WITH HOUSEKEEPING DUTIES | <input type="checkbox"/> OTHER: _____ |

PLACE AN "X" ON THE SCALE WHERE IT BEST DESCRIBES THE AMOUNT OF PAIN YOU ARE FEELING:

