GOODLIFE
PHYSICAL THERAPY

PATIENT REGISTRATION				
Last Name:	**First Name:**		**Middle:**	
Address:	**City:**		**State:**	**Zip:**
Social Security #	**DOB:** (mm/dd/yyyy)	**Age:**	**Cell Phone:**	**Home Phone:**
E-mail address:	**May we add you to our email newsletter?** **Y** **N**			
Preferred Method of Contact: ☐ Cell ☐ Home ☐ E-Mail	**Emergency Contact Name and Relationship:**		**Emergency Contact Phone Number:**	

PHYSICIAN INFORMATION	
Referring Physician:	**Primary Care Physician:**

HOW DID YOU HEAR ABOUT US?		
☐ Family/Friend ☐ Physician Referral ☐ Past Patient	☐ Social Media/Yelp ☐ Google, Yahoo, or Bing Search ☐ Attended Workshop/Event Booth	☐ Insurance Co. Recommendation ☐ Workers' Comp/Case Manager ☐ Other:_____

INSURANCE INFORMATION			
Primary Insurance Company:	**Identification #:** **Group #:**		**Policy Holder: (if other than patient)**
Relationship to Patient:	**Policy Holder DOB:**	**Policy Holder SS#:**	**Policy Holder Phone#:**
Secondary Insurance Company:	**Identification #:** **Group #**		**Policy Holder: (if other than patient)**
Relationship to Patient:	**Policy Holder DOB:**		**Policy Holder SS#:**
Policy Holder DOB:	**Policy Holder SS#:**		**Policy Holder Phone#:**

I, the undersigned, hereby certify that I have answered the questions listed above accurately and to the best of my knowledge

Patient/Parent or Guardian Signature:

PATIENT MEDICAL HISTORY

Reason for Visit/Main Complaint:	Date Symptoms Began: (mm/dd/yyy)	Height: Weight:

Have you previously received treatment for this complaint: ☐ YES ☐ NO If YES, what did you receive:	Have you received any special tests related to this complaint? ☐ YES ☐ NO If YES, please select which one(s): ☐ MRI ☐ CT Scan ☐ X-Ray ☐ Bone Scan Other, please specify:	In the past 2 years, have you undergone any surgical procedures: ☐ YES ☐ NO If YES, please explain: Date of procedure:

In the past two years, have you been hospitalized: ☐ YES ☐ NO If YES, please explain: Date of hospitalization:	**Please list any medications you are currently taking and for what:** (or provide a copy)

Rate your Symptom intensity on a scale of 0 – 10 (0=no pain) At Best: At Worst: **Name 3 activities impacted by your condition.** **1.** **2.** **3.**	**Describe your current symptoms (e.g. Dizziness, Vertigo, Lightheadedness, Imbalance, etc):**

PATIENT HEALTH HISTORY

Have you been diagnosed with any of the following conditions?

☐ Allergies	☐ Depression	☐ Joint Replacement
☐ Anemia	☐ Diabetes	☐ Kidney Stones
☐ Angina/Chest Pain	☐ Defibrillator	☐ Metal Implants
☐ Anxiety/Panic Attacks	☐ Dizziness	☐ Multiple Sclerosis
☐ Arrhythmia	☐ Emphysema	☐ Night Sweats
☐ Arthritis	☐ Fever for 2 or more weeks	☐ Osteoporosis
☐ Asthma	☐ Fibromyalgia	☐ Parkinson's Disease
☐ Blood Pressure	☐ GERD	☐ Seizures
☐ Cancer	☐ Headaches	☐ Stroke
☐ Chronic Bronchitis	☐ Heart Attack	☐ Ulcers
☐ Cirrhosis/Liver Disease	☐ High Cholesterol	☐ Unexplained weight loss
☐ Chronic Coughing	☐ Hypertension	☐ Other, please explain

I, the undersigned, hereby certify that I have answered the questions listed above accurately and to the best of my knowledge

Patient/Parent or Guardian Signature:	Date:

CONSENT FOR TREATMENT

I voluntarily consent to receive treatment at Goodlife Physical Therapy. I permit its employees and all other persons caring for me to treat me in ways they judge are necessary and proper in diagnosing and treating my physical condition. No guarantees have been made to me about the outcome of this care.

Patient/Guardian Signature _____ Date _____

ASSIGNMENT OF BENEFITS / RELEASE OF INFORMATION

I hereby assign all medical benefits to which I am entitled to Goodlife Physical Therapy in the event they file on my behalf. I hereby authorize said assignee to release all information, verbal and written, contained in my medical records, to secure payment.

I understand that I am financially responsible for all charged whether or not paid by said insurance. Verification of benefits is not a guarantee of payment according to actual benefits quoted. In the event that my account becomes delinquent and is therefore in default of payment, I accept responsibility for the principal amount as well as all reasonable costs associated with the collection of this debt, including but not limited to collection of service fees, attorney's fees, and all court costs and additional legal fees.

Patient/Guardian Signature _____ Date _____

NO SHOW / CANCELLATION POLICY

We at Goodlife Physical Therapy are dedicated to assisting you meet your therapy goals. In order to do this, it is important that you attend all your scheduled appointments. We realize that there are times when unforeseen circumstances make it impossible to attend your scheduled appointment. If this happens, please give us as much notice as possible so we can reschedule your appointment and open that time slot for another patient. You can call us at 708.645.7700.

Broken appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you.

In order to enforce this policy, you will be charged **$50.00 if you cancel an appointment less than 24 hours** before your scheduled appointment and **$75.00 if you do not show** for your appointment.

If you are a worker's compensation patient, please be advised that your employer, physician, and case manager will be notified of each missed appointment.

Patient/Guardian Signature _____ Date _____

MEDICARE ASSIGNMENT

I certify that the information I gave in applying for payment of Medicare benefits is correct. I assign Medicare benefits payable to Goodlife Physical Therapy and I understand that I am responsible for any health deductibles and co-insurance amounts not covered by Medicare and/or my secondary insurance. (Please leave blank if not applicable to you)

Patient/Guardian Signature _____ Date _____

HIPPA NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have read the Notice of Privacy Practices for Goodlife Physical Therapy. The therapist is required by applicable federal and state law to maintain the privacy of your protected health information. We are required to give you a notice about our policy practices and your rights concerning protected health information. We reserve the right to change our policy privacy practices. A copy of our Notice of Privacy Practices is available to you upon your request.

Patient/Guardian Signature _____ Date _____

FINANCIAL RESPONSIBILTY

I understand that insurance coverage is not a guarantee of payment, and that I am ultimately responsible for services rendered at Goodlife Physical. I will honor Goodlife Physical Therapy's payment policy as stated below:

- All co-payments and cash payment are due in full at the time of service
- Co-insurance and deductibles are the patient's responsibility and will be invoiced once the patient's insurance provider provides the Explanation of Benefits (EOB). Invoices will be due 30 days after receipt.
- I authorize payment of benefits directly to Goodlife Physical Therapy for services provided.
- Goodlife Physical Therapy has the right to consult a collection agency if payment is past due 90 days. If any portion of the account balance exceeds 60 days the patient will charged $10 for each month the balance remains outstanding.
- I understand that I am financially responsible for payment of all services that are not paid by my insurance provider. Should my account be referred to collection, I will be responsible to pay costs of collections, including legal fees.
- I understand a fee of $25.00 will be assessed for any check returned unpaid.
- **I understand a fee of $20.00 will be charged for medical records upon my request due to the time and cost of producing the copies.**

Patient/Guardian Signature _____ Date _____

DIZZINESS HANDICAP INDEX

The purpose of this scale is to identify difficulties you may be experiencing because of your dizziness or vertigo. For each statement, please select either: Yes, No, or Sometimes as it pertains to your dizziness or vertigo.

Y = Yes N = No S = Sometimes

	Y, N or S
Does looking up increase your problem?	
Because of your problem, do you feel frustrated?	
Because of your problem, do you restrict your travel for business or pleasure?	
Does walking down the aisle of a supermarket increase your problem?	
Because of your condition, do you have difficulty getting into or out of bed?	
Does your problem significantly restrict your participation in social activities, such as going out to dinner, going to the movies, dancing or to parties?	
Because of your problem, do you have difficulty reading?	
Does performing more ambitious activities like sports, dancing, and household chores, such as sweeping or putting dishes away; increase your problem?	
Because of your problem, are you afraid to leave your home without having someone accompany you?	
Because of your problem, have you been embarrassed in front of others?	
Do quick movements of your head increase your problem?	
Because of your problem, do you avoid heights?	
Does turning over in bed increase your problem?	
Because of your problem, is it difficult for you to do strenuous housework or yard work?	
Because of your problem, is it difficult for you to go for a walk by yourself?	
Because of your problem, are you afraid people may think that you are intoxicated?	
Does walking down a sidewalk increase your problem?	
Because of your problem, is it difficult for you to concentrate?	
Because of your problem, is it difficult for you to walk around you house in the dark?	
Because of your problem, are you afraid to stay home alone?	
Because of your problem, do you feel handicapped?	
Has your problem placed stress on your relationship with members of your family or friends?	
Because of your problem, are you depressed?	
Does your problem interfere with your job or household responsibilities?	
Does bending over increase your problem?	

CONFIDENCE INDEX

For each of the activities, please indicate your level of confidence in performing each without losing your balance or becoming unsteady by selecting a percentage from 0 -100%. If you do not normally participate in a particular activity, try to imagine how confident you would be if you had to perform the activity.

If you use a walking aid or any assistance to perform the activity, rate your confidence as if you were using these supports. Please use the following scale.

0% 100%

No Confidence Completely Confident

	Confidence %
Walking around the house	
Walking up or down the stairs	
Bend over and pick up a slipper from the front of a closet floor	
Reaching for a small can off the shelf at eye level	
Standing on your tiptoes and reaching for something above your head	
Stand on a chair and reach for something	
Sweeping the floor	
Walking outside of the house to a parked car in the driveway	
Getting in or out of a car	
Walking across the parking lot to a mall	
Walking up or down a ramp	
Walking in a crowd mall where people are rapidly walking past you	
Bumped into by people as you walk through the mall	
Stepping on or off an escalator while holding on to the rail	
Stepping on or off an escalator while holding onto bags, thus unable to hold the railing	
Walking outside on a wet or slippery sidewalk	