



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? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Preferred Method of Contact: <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> E-Mail		Emergency Contact Name and Relationship:			Emergency Contact Phone Number:			

PHYSICIAN INFORMATION

Referring Physician:		Primary Care Physician:	
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HOW DID YOU HEAR ABOUT US?

<input type="checkbox"/> Family/Friend	<input type="checkbox"/> Social Media/Yelp	<input type="checkbox"/> Insurance Co. Recommendation
<input type="checkbox"/> Physician Referral	<input type="checkbox"/> Google, Yahoo, or Bing Search	<input type="checkbox"/> Workers' Comp/Case Manager
<input type="checkbox"/> Past Patient	<input type="checkbox"/> Attended Workshop/Event Booth	<input type="checkbox"/> Other: _____

INSURANCE INFORMATION

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

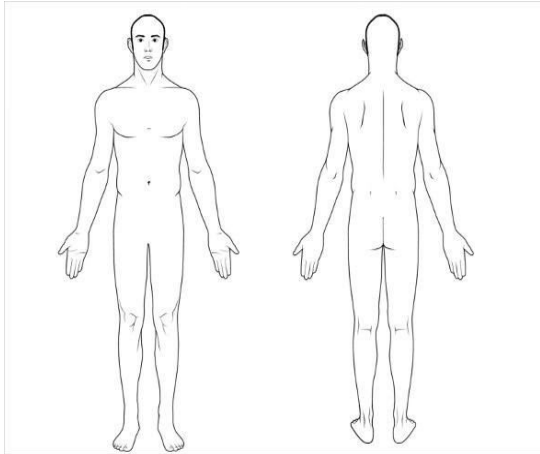
I, the undersigned, hereby certify that I have answered the questions listed above accurately and to the best of my knowledge

Patient/Parent or Guardian Signature:



PATIENT MEDICAL HISTORY

Patient Name:	Reason for Visit/Main Complaint:	Location of Pain: Date Symptoms Began: (mm/dd/yyyy)
Have you previously received treatment for this complaint: <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, what did you receive:	Have you received any special tests related to this complaint? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, please select which one(s): <input type="checkbox"/> MRI <input type="checkbox"/> CT Scan <input type="checkbox"/> X-Ray <input type="checkbox"/> Bone Scan Other, please specify:	In the past 2 years, have you undergone any surgical procedures or hospitalization? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, please explain: Date of procedure:
Height: Weight:	List any medications you are currently taking or provide a copy:	

<p>Please indicate which of these words, if any, describe your pain. Select all that apply.</p> <p><input type="checkbox"/> Aching <input type="checkbox"/> Numb <input type="checkbox"/> Shooting <input type="checkbox"/> Tingling <input type="checkbox"/> Burning <input type="checkbox"/> Sharp <input type="checkbox"/> Throbbing <input type="checkbox"/> Other, explain</p> <p>Rate your pain intensity on a scale of 0 – 10 (0=no pain) At Best:</p> <p>At Worst:</p> <p>Name 3 activities impacted by your condition.</p> <p>1.</p> <p>2.</p> <p>3.</p>	<p>On the body diagram below, please indicate where your current symptoms are located at the present time.</p> <p>X Pain ///// Numbness ^^^^ Tingling, Throbbing, Other</p> <div style="text-align: center;">  </div>
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PATIENT HEALTH HISTORY

Have you been diagnosed with any of the following conditions?		
<input type="checkbox"/> Allergies <input type="checkbox"/> Anemia <input type="checkbox"/> Angina/Chest Pain <input type="checkbox"/> Anxiety/Panic Attacks <input type="checkbox"/> Arrhythmia <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Blood Pressure <input type="checkbox"/> Cancer <input type="checkbox"/> Chronic Bronchitis <input type="checkbox"/> Cirrhosis/Liver Disease <input type="checkbox"/> Chronic Coughing	<input type="checkbox"/> Depression <input type="checkbox"/> Diabetes <input type="checkbox"/> Defibrillator <input type="checkbox"/> Dizziness <input type="checkbox"/> Emphysema <input type="checkbox"/> Fever for 2 or more weeks <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> GERD <input type="checkbox"/> Headaches <input type="checkbox"/> Heart Attack <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Joint Replacement	<input type="checkbox"/> Kidney Stones <input type="checkbox"/> Metal Implants <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Night Sweats <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Parkinson’s Disease <input type="checkbox"/> Seizures <input type="checkbox"/> Stroke <input type="checkbox"/> Ulcers <input type="checkbox"/> Unexplained weight loss <input type="checkbox"/> Other:

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:
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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 708.966.4386.

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 RESPONSIBILITY

I understand that insurance coverage is not guarantee of payment, and that I am ultimately responsible for services rendered at Goodlife Physical Therapy. I will honor Goodlife PT'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 be 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 _____