GRAYSLAKE REHABILITATION

PHYSICAL THERAPY • AQUA THERAPY • WELLNESS

PATIENT INFORMATION FORM

FULL NAME: _____ **NICKNAME:** _____

STREET ADDRESS: _____ **APT #:** _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

DATE OF BIRTH: _____ **GENDER:** _____

EMPLOYER/COMPANY NAME: _____

EMAIL ADDRESS: _____

PHONE: (HOME) _____ **(CELL)** _____

If patient is under 18, please complete the following:

PARENT/GUARDIAN NAME: _____

RELATIONSHIP TO PATIENT: _____ **DATE OF BIRTH:** _____

EMERGENCY CONTACT: _____ **PHONE:**_____

REFERRING PHYSICIAN: _____ **LOCATION:** _____

WORK STATUS: EMPLOYED RETIRED DISABLED (__total or ___temporary) S TUDENT

MY INJURY/AILMENT IS RELATED TO: AUTO/PERSONAL INJURY WORK INJURY NO INJURY

I HAVE ALREADY HAD: SURGERY PT BEFORE HOME HEALTH CARE OTHER_____

Have you verified your physical therapy benefits with your insurance? Yes No

—If no, we strongly encourage you to do so, in order to help you understand your benefits and Physical Therapy coverage.

How did you hear about Grayslake Rehabilitation?

___ Suggested by referring physician

___ Referred by a former patient (please list their name so we can thank them!): _____

___ Found GLR online (please specify): ___ Google ___ Yelp ___ Facebook ___ Other: _____

___ Insurance Company

___ Walk-by

___ I'm a former patient

___ Other (please specify): _____

GRAYSLAKE REHABILITATION

PHYSICAL THERAPY • AQUA THERAPY • WELLNESS

Health Insurance Benefit Information

(Please Print)

Primary Carrier Name	Mailing Address			
ID No	Group No.			Employer
Policy Holder	Sex	Relation to Patient	Date of Birth	Social Security No.

Secondary Carrier Name	Mailing Address			
ID No	Group No.			Employer
Policy Holder	Sex	Relation to Patient	Date of Birth	Social Security No.

Worker's Compensation Carrier Name	Mailing Address	
Claim No	Date of Accident	Adjuster's Name/Phone No.

I certify that the above information is correct. I understand that I am personally responsible to pay all charges for services rendered to me and agree to make payment, thereof, when due. Any billing sent by the provider to an insurance company, attorney, or other third party is for the accommodation of the patient and does not relieve the undersigned to pay charges for services provided. If it is determined by the Worker's Compensation Board that the illness or condition is not a result of a compensable Worker's case, I agree to pay Grayslake Rehabilitation for services rendered. I authorize payment for these services be paid directly to Grayslake Rehabilitation.

Signature_____ Date_____

GRAYSLAKE
REHABILITATION
PHYSICAL THERAPY • AQUA THERAPY • WELLNESS

CONSENT FOR CARE AND TREATMENT
I the undersigned, having legal authority to do so, do hereby agree and give consent for Grayslake Rehabilitation to furnish medical care and treatment to as considered necessary and proper in diagnosing or treating my/his/her condition.

BENEFIT ASSIGNMENT / RELEASE OF INFORMATION
I hereby assign all medical benefits, including major medical benefits, Medicare, private insurance and any other health plans to which I am entitled, to Grayslake Rehabilitation. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize the release of all information necessary, including Medical Records, to secure payment.

FINANCIAL POLICY STATEMENT
Grayslake Rehabilitation bills your insurance carrier as a courtesy to you, although you are responsible for the entire bill when services are rendered. We require that arrangements for payment of your estimated portion of the bill be made today. This includes co-payments, co-insurance, and deductibles if required by your health insurance carrier. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. If payment is subsequently made by your insurance carrier in excess of the balance of your account, we will promptly refund the credit. I understand and agree that I am personally responsible for making full payment for all charges resulting from this Consent for Services. If payment is made directly to you for services billed by us, you agree to promptly remit the payment to Grayslake Rehabilitation. The above does not apply for those patients covered by Workers' Compensation Act. However, a Workers' Compensation patient may be responsible for the charges if the claim is denied. In event my balances remain unpaid for any reason; I agree to pay a penalty of 30% of the open balance to cover collections agency fees and/or attorney fees in addition to court costs.

SCHEDULING AND CANCELLATION POLICY
Grayslake Rehabilitation reserves the right to bill a **$50.00 no show fee** if we are not notified that you are unable to attend your scheduled appointment. If you cannot attend your scheduled appointment time, we ask that you notify us **24 hours prior** to your appointment so we may accommodate other patients. Consistency in treatment is important to your rehabilitation outcome and multiple cancellations may result in termination of your treatment or a loss of desired schedule time.

PATIENT IDENTITY
My signature below means that I have given truthful information about my name and identity. It also means that I understand:
- How important it is to provide truthful information about my condition
- That incorrect or false information about my condition can lead to treatment that could harm this patient
- That Grayslake Rehabilitation reserves the right to take action for intentional presentation of false information including transfer of care and appropriate reporting to authorities.

Thank you in advance for choosing Grayslake Rehabilitation for your physical therapy needs. I acknowledge and understand the information that was given to me.

Patient: _____Date:_____

Guardian/ Responsible Party: _____Date:_____

GRAYSLAKE REHABILITATION

PHYSICAL THERAPY • AQUA THERAPY • WELLNESS

We are pleased and honored that you and/or your referring physician have trusted us with your care. We hope that after your first visit you will feel valued and well taken care of. Physical Therapy is a tool, a pathway to get you to your goals. Our highly trained staff members at Grayslake Rehab strive to do their best to make your experience pleasant. As part of this relationship, we wish to review expectations of your financial responsibility as outlined in our Financial Policy.

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY

- **Insurance benefits are checked by the Grayslake Rehab Billing Department as a courtesy to the patient.** Please provide insurance cards upon first visit to ensure that claims are submitted promptly. All co-payments are due at the time of service. For deductible plans- if you owe more than $200 towards your deductible and do not have an HSA or HRA, we will collect up to $120 each visit and balance bill you the remainder. Co-insurances and fees not covered by your insurance policy will be billed to you upon receipt of insurance remittance. If you cannot pay upfront, the billing department may be able to work with you to set up a payment plan. In the rare case the insurance denies claims because information needs to be verified by you, the balance will be shifted to you until the issue is resolved with your insurance company. If you are unwilling to call the insurance company to give the required information, you will be responsible for the entire amount of the bill.

- It is important to understand that **the patient is under contract with their own insurance company.** The amount owed to the provider (Grayslake Rehab) is 100% determined by the patient's policy. **The amount owed to the provider (Grayslake Rehab) is never determined by Grayslake Rehab.** This includes unmet deductibles, co-pays, or co-insurances. In general, it is not acceptable for a patient not to pay the amount owed to the provider (Grayslake Rehab) because it is a breach of the contract with the patient's insurance company. In addition, Grayslake Rehab is in contract (in network) with most insurance companies and therefore, where applicable, will write off anything over what is allowable by contract. Billing is done on a daily basis to all insurance companies.

- **Please do not ask the billing department to adjust off any charges, deductibles or co-pays over what is allowed by insurance as it is generally not permitted for them to do so.** It is VERY important for the patient to take responsibility in knowing his/her individual benefits and what insurance will allow so unexpected balances do not occur. **The Grayslake Rehab Billing Department files with many insurance's and most offer several different plans, therefore it is the patient who must make sure the benefits checked are what match their plan.**

- In the case the patient needs a service that is not covered by the in network agreement, Grayslake Rehab will notify the patient to see if the patient agrees to the service. The billing department will then make arrangements to charge and bill the patient accordingly.

- If you do not have In-Network Medical Insurance, please speak with our billing coordinator to discuss self-pay options. **Please note: There is no payment plan option for our self pay patients.**

- **Third Party/Workers Comp:** We are happy to see personal injury patients. The billing department will need information such as claim number, adjuster's name and contact phone number and mailing address. Should the Third Party/Workers Comp deny our claims; the claims will be submitted to your Medical Insurance or become your responsibility.

GRAYSLAKE REHABILITATION

PHYSICAL THERAPY • AQUA THERAPY • WELLNESS

- **Minors and Dependents:** Parents and guardians are responsible for payment for their dependents at the time service is rendered.

- Billing statements are sent to patients with a personal balance on a monthly basis. We ask that upon receipt of such a statement, payment is sent to our office within fifteen (15) days of receipt. If you have a financial hardship or you are unable to pay the balance in its entirety, please contact our billing coordinator to discuss payment options. **If your account becomes delinquent and you have not established or met payment options with our billing office, your account will be turned over to our outside collection agency.**

Helpful Definitions

When you come into the financial office or even reading your Explanation of Benefits from your insurance company, often times there are terms that are used that you may not understand. Below we have provided sample definitions of these terms for you in hopes that this will help you better understand some of your coverage. (Note that your insurance company may define these terms differently.)

Deductible:
The amount you owe for covered health care services before your health insurance or plan begins to pay. For example, if your deductible is $2,000, your plan won't pay anything until you have met your $2,000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

Co-insurance:
Your share of the costs of a covered health care service, calculated as a percent (for example 20%) of the allowed amount for the service. You pay co-insurance plus any deductible you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

Co-payment:
Co-pay- is the set fee for a particular service that is determined by the patient's medical insurance policy. For example, if you have a $15 co-pay for physical therapy; then you pay $15 each visit.

Out of Pocket Max:
The out of pocket max (OOP) is a cap on how much the patient has to pay for the individual or family covered medical expenses each year. After the OOP max is met, the insurance plan pays 100% of all remaining covered expenses for that year.

We look forward to providing you with Excellent Physical Therapy services!!!

Signature_____ Date_____

GRAYSLAKE REHABILITATION
PHYSICAL THERAPY • AQUA THERAPY • WELLNESS

Patient Balance Payment Agreement

Our practice is acutely aware of the ever escalating health care costs and we are doing everything feasible to help lower costs through increased efficiency. Recent changes in health care benefits have resulted in larger patient co-pays, deductibles and co-insurance.

It is costly and inefficient to send patients a monthly statement We request that you assist us in helping to reduce billing costs by completing the credit card authorization below. By signing the authorization, you can be assured that your credit card information will be securely stored and charged only for those fees your insurance company does not pay. We honor all contractual obligations with insurance companies with which we participate. You will never be charged in excess of the allowed amounts.

For those patients who would prefer to pay their balance by check, a debit card, or another credit card once we know your balance, we will mail you one statement for the full amount due. Full payment will be due 30 days from the statement date (if payment is not received in 60 days, the credit card you have on file will be charged the full amount due after insurance has paid its portion.)

We also accept checks. When you pay by check, if your check is returned for any reason, you expressly authorize Grayslake Rehabilitation to debit your account for the amount of the check plus a processing fee of $30. The use of a check for payment is your acknowledgement and acceptance of this policy.

Credit Card Authorization

I authorize Grayslake Rehabilitation, LLC. to keep my signature on file and to charge my credit card account listed below for co-pays, co-insurance, and deductible amount not collected at time of service. In addition, I authorize Grayslake Rehabilitation, LLC. to charge my credit card for any outstanding account balances following insurance determination, including fees due to late cancellation or non-attendance of scheduled apointments.

(Please sign and date this agreement, then present your credit card to receptionist)

Patient Name: _____

Name of Cardholder:_____

Type of Card on File: **HSA** **FLEX** **VISA** **MASTERCARD** **DISCOVER**

Last four of Card Authorized:_____ Expiration Date: _____

Signature:_____

GRAYSLAKE REHABILITATION
PHYSICAL THERAPY • AQUA THERAPY • WELLNESS

PRE-EXAM QUESTIONAIRE

_____ _____ _____
FIRST NAME LAST NAME AGE DATE OF BIRTH

_____ Are you working now? _____Yes _____No
OCCUPATION

What problem/issue brings you in today? _____

What date (roughly) did your present symptoms start? _____

How did this issue begin? _____

Rate your pain on a scale of 0-10 (0=no pain; 10=worst pain): _____ _____ _____
CURRENT BEST WORST

Are any of your everyday activities affected? ____NO ____if YES, How_____

What are you expecting from your PT program? _____

What are some potential obstacles to getting better?_____

Have you recently experienced any of the following (check all that apply)?

___ Changes in bowel/bladder function
___ Shortness of breath
___ Nausea/vomiting
___ Weakness/fatigue
___ Loss of control of urine
___ Headaches
___ Dizziness/lightheadedness
___ Difficulty maintaining balance while walking
___ Difficulty swallowing
___ Unintended weight loss/gain
___ Numbness/tingling
___ Fever/chills/sweats
___ Pain at night
___ Changes in appetite
___ Pain caused by cough or sneeze
___ Frequent falls

Please explain: _____

_____

Please describe any surgical history (include dates): _____

_____

Other medical history (check all that apply):

___ Diabetes
___ Cancer
___ High blood pressure
___ Cardiovascular conditions
___ Rheumatoid arthritis
___ Osteoarthritis
___ Fractures
___ Motor vehicle accidents
___ Osteoporosis
___ HIV
___ Immunosuppression
___ Neurological conditions
___ Chronic aches/pain
___ Stroke/TIA
___ Current infection

Please explain: _____

_____

I understand that my candidacy for a rehabilitation program will be dependent upon my ability and willingness to improve. I have answered the questions above honestly and accurately to the best of my ability. The therapist will determine whether or not I am a viable candidate for a rehabilitation program and that my activation into their system is not guaranteed.

Signature:_____ Date_____

GRAYSLAKE
REHABILITATION
PHYSICAL THERAPY • AQUA THERAPY • WELLNESS

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

LIST ALL KNOWN DRUG ALLERGIES:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____ _____

PATIENT NAME DATE OF BIRTH DATE

GRAYSLAKE REHABILITATION
PHYSICAL THERAPY • AQUA THERAPY • WELLNESS

Statement of Privacy Notice

Effective June 1, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

We may disclose your health information in the course of any administrative or judicial proceeding.

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

We may disclose your health information to coroners or medical examiners.

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

We may disclose your health information for military, national security, prisoner and government benefits purposes.

We may leave a message on an automated answering device or person answering the phone for the purposes of scheduling appointments. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."

We may contact you by phone, mail, or email. "It is our practice to participate in charitable and marketing events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity.

In the event that we are sold or merged with another organization, your health information/record will become the property of the new owner.

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that we are not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that we amend your protected health information. Please be advised, however, that we are not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by us.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

We reserve the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice.

We are required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact us by calling this office at (951) 279-0777. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints about your Privacy rights, or how we have handled your health information should be directed to our Privacy Officer by calling this office at (951) 279-0777. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Grayslake Rehab with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

_____
Patient's Name (print)

_____
Patient's Signature Date

_____
Authorized Facility Signature Date