GIVEN
SPORTS & PHYSICAL THERAPY
EXPERTISE • EXPERIENCE • PERSONAL ATTENTION

Featuring McHenry County's First Board Certified Clinical Specialist

Consent for Care & Treatment: I agree and give consent for Given Sports & Physical Therapy, PC to provide medical care and treatment as considered medically necessary in evaluating and treating my physical condition. I will provide proper identification, accurate insurance and injury information as needed at the time of the initial evaluation. If under the age of 18 years old it is required to have a signed consent from a parent/guardian.

Benefit Assignment/Release of Information: I agree to assign all my rights and claims for reimbursement under my health insurance policy to Given Sports & Physical Therapy, PC for services rendered. I hereby authorize release of all information necessary to secure payment for these services.

Notice of Privacy Practices: I acknowledge that the Notice of Privacy Practices has been made available for my review. My signature indicates understanding and agreement with said Notice that outlines how my health information may be used, disclosed and how I am able to gain control of my health information. I understand the Notice of Privacy Practices (posted at www.givensports.com and available for review in the clinic itself) and consent to disclosure for permitted uses.

- I give consent for Given Sports & Physical Therapy, PC to communicate with the following individuals regarding provided treatment services and explanation of benefits/billing.

Name_____ Relationship _____ Phone _____

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Financial Policy Explanation: I, the patient, am fully responsible and understand my individual benefits and plan details. I understand that pre-verification of benefits/coverage is only an estimate of coverage and not a guarantee of payment. If benefits are subsequently denied by my insurance company, I understand and agree that I am fully responsible for the charge of rendered services. I am aware that some insurance plans require specific pre-authorization or referral for physical therapy. If my insurance carrier does not remit payment within 120 days, I understand the balance will be my responsibility and is due at that time. I agree to pay a $25 charge assessed for any dishonored/returned check or any failed payment transaction. Pre-collection notices may be sent after the same patient balance is billed on two consecutive occasions. I agree to pay for all costs of collecting monies including court costs, additional collection agency fees of 40%, and attorney fees incurred. I understand that all medical supply payments are due in full at the time of receipt as these are not billed to any insurer and payment for medical goods is non-refundable

Commercial Insurance: I understand that insurance companies require that co-payments be paid at the time of service. I agree to pay the estimated co-insurance and deductible payments at the time of service. After an EOB is received from my insurance company, I understand I am responsible for any remaining balance. I give my permission for any refund due to be credited to an active account or for a refund check to be issued once all insurance payments are received.
Medicare: I understand claims will be submitted to Medicare and any supplementary/secondary plan. I will speak directly to the therapist about the implications of calendar year caps on Medicare services. I am responsible to notify this office if any home health therapy or nursing services have just concluded or occur during the course of therapy.
Workers' Compensation: I understand that Given Sports & Physical Therapy, PC will notify case managers/adjusters of missed or cancelled appointments.
Auto/Personal Injury: I understand my options for Auto/Personal Injury are 1) elect to self-pay for services or 2) elect that this office bills my personal health or auto insurance. My personal health insurance shall be considered a secondary payor to auto insurance. I understand and acknowledge no 3rd party billing is allowed.
Self-pay: I understand and agree payment is due at the time of service at the lesser of $25 per billable units charged or $125 max amount per treatment session.

Attendance Policy: I understand that my prescribed frequency of physical therapy and suggested home exercise program is a vital component of my progress with physical therapy. If I need to cancel/reschedule an appointment, I will give at least 24 hours notice and Given Sports & Physical Therapy, PC will make every effort to keep my prescribed frequency of therapy. If I am unable to reschedule a missed appointment during the same week of therapy I will be charged a $25 No Show fee. This fee will not be charged to my insurance, instead the fee will be paid at my next appointment. I understand that Given Sports & Physical Therapy, PC will notify my referring physician of my attendance and compliance with physical therapy. If I have repeated non-compliance with therapy, I understand that Given Sports & Physical Therapy, PC reserves the right to discontinue my care and will notify my physician of this reason.

By signing below, I certify that I have read, understand and agree to each of the statements in this document.

Signature of Patient/Guardian/Responsible Party _____ **Date**_____

Version 5.21.2019

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P.O. Box 509077, San Diego, CA 92150-9077

INITIAL HEALTH STATUS

PT OT ST AT Fax: 877.248.2746

Patient Name_____ Subscriber ID #_____ Primary Language_____

Describe Your Current Problem and How It Began_____

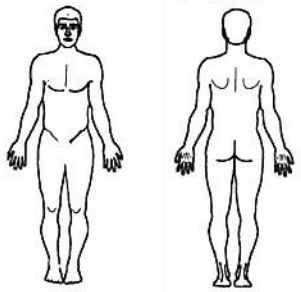
_____

_____

Onset date/Surgery date_____

Is this? ☐ Work Related ☐ Auto Related ☐ N/A

Indicate below where you have pain or other symptoms



How often are your symptoms present?

☐ Constantly (76-100% of the day) ☐ Occasionally (26-50% of the day)
☐ Frequently (51-75% of the day) ☐ Intermittently (0-25% of the day)

Describe the nature of your pain:

☐ Sharp ☐ Dull Ache ☐ Numb ☐ Shooting ☐ Burning ☐ Tingling

How is your condition changing?

☐ Getting Better ☐ Not Changing ☐ Getting Worse

Current complaint (how you feel today):

No pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable pain

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores)?

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

Check if you have difficulty: ☐ Seeing ☐ Hearing ☐ Talking ☐ Memory ☐ Swallowing

What is your most effective learning method: ☐ Seeing ☐ Hearing ☐ Talking ☐ Doing ☐ Pictures

In general would you say your overall health right now is:

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Have you had x-rays, MRI, CT Scan for your area(s) of complaint? ☐ Yes ☐ No

Date(s) taken_____ **What areas were taken?**_____

Please check all of the following that apply to you:

☐ Alcohol/Drug Dependence
☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Cardiac Condition
☐ Stroke (Date)_____
☐ Dizziness/Fainting
☐ Cancer/Tumor (Explain)_____
_____
☐ Osteoporosis
☐ Other Health Problems (Explain)_____
_____

☐ Numbness (Location)_____
☐ Urinary Problems
☐ Currently Pregnant, # Weeks_____
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Surgeries_____
_____
☐ Tobacco Use - Type_____
Frequency_____/Day
☐ Current Medications_____
_____

Who have you seen for your condition before today? ☐ No One

☐ Medical Doctor ☐ Massage Therapist ☐ Chiropractor ☐ Other_____
☐ Physical Therapist ☐ Acupuncturist ☐ Occupational Therapist ☐ Speech Therapist ☐ Athletic Trainer

What treatment did you receive and when?_____

What is your occupation?_____

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider/practitioner, I understand that I am liable for all charges for services rendered and I agree to notify this provider/practitioner immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that this provider/practitioner may need to contact my physician if my condition needs to be co-managed. Therefore, I give authorization to this provider/practitioner to contact my physician, if necessary.

Patient/Responsible Party Signature_____ **Date**_____