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**_____

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Patient Health Questionnaire

Name: _____ Date: _____

Date of Birth: _____ *Patient Acct#*: _____

Referring Physician: _____ Family Physician: _____

Date of 1st doctor visit for this injury/condition: _____

Are you aware of what your diagnosis is? ①Yes ②No

What are your rehabilitation expectations or goals? _____

Have you had Surgery for this injury? ①Yes ②No _____

Type of Surgery: _____ Approx date(s) of surgery: _____

Your chief complaint: _____

Date of onset of symptoms or Injury: _____

How often do you experience your symptoms? ①Constantly (76-100% of the day)
②Frequently (51-75% of the day)
③Occasionally (26-50% of the day)
④Intermittently (0-25% of the day)

What describes the nature of your symptoms: *(Choose all that apply)*

①Sharp ②Dull ache ③Numb ④Shooting ⑤Burning ⑥Tingling

How are symptoms changing: ①Getting better ②Not changing ③Getting worse

During the past 4 weeks:

a. *Indicate the average intensity of your symptoms:*

None Unbearable

① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

b. How much pain interfered with your normal work:

(*including both work outside the home and housework*)?

①Not at all ② A little bit ③Moderately ④Quite a bit ⑤ Extremely

During the past 4 weeks how much of the time has your condition interfered with your social activities? *(visiting with friends, relatives, etc.)*

①All of the time ③Some of the time ⑤None of the time

②A little of the time ④ Most of the time

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

①Excellent ②Very good ③Good ④Fair ⑤Poor

Who have you seen for your symptoms? *(Choose all that apply)*

① No One ②Physical Therapist ③Chiropractor ④Other

⑤ Medical Doctor ⑥Occupational Therapist ⑦ Orthopedist _____

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

①Xrays ②MRI ③CT Scan ④Other: _____

c. What medication are you currently taking for this injury? _____

Have you had similar symptoms in the past? ①Yes ②No

If you have received treatment in the past for the same/similar symptoms, who did you see?

①This Office ②Medical Doctor ③Other ④Occupational Therapist

⑤Chiropractor ⑥Physical Therapist ⑦ Orthopedist _____

What is your occupation? ①Professional/Executive ②Laborer ③Retired

_____ ④White Collar/Secretarial ⑤Homemaker ⑥Other

⑦ Tradesperson ⑧ Student

If you are not retired, a homemaker, or a student, what is your current work status?

①Full-time ②Part-time ③Self-employed ④Unemployed ⑤Off work ⑥Other

Patient/Guardian Signature: _____ **Date:** _____

I have reviewed and discussed this patient medical information with the patient

Therapist Signature: _____ **Date:** _____

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Please circle ***Y (yes)*** or ***N (no)*** if you have, or have had condition. Circle ***M (medications)*** if you are taking medications for the condition.

General			
Good general health	Y	N	M
Recent weight changes	Y	N	M
Fatigue	Y	N	M
Night sweats / fevers	Y	N	M
Cardiovascular			
Angina / chest pain	Y	N	M
Coronary artery disease	Y	N	M
Heart surgery	Y	N	M
Pacemaker	Y	N	M
Musculoskeletal			
Muscle pains or cramps	Y	N	M
Stiffness / swelling in joints	Y	N	M
Joint pain	Y	N	M
Osteoporosis	Y	N	M
Endocrine			
Excessive thirst / urination	Y	N	M
Thyroid disease	Y	N	M
Hormone problem(s)	Y	N	M
Ear / Nose / Throat / Mouth			
Hearing loss / ringing in ears	Y	N	M
Sinus problems	Y	N	M
Nose bleeds	Y	N	M
Sore throat	Y	N	M
Voice changes	Y	N	M
Respiratory			
Shortness of breath	Y	N	M
Excessive coughing	Y	N	M
Asthma	Y	N	M
Bronchitis	Y	N	M
Emphysema	Y	N	M
Neurological			
Frequent headaches	Y	N	M
Seizures / Epilepsy	Y	N	M
Numbness / tingling	Y	N	M
Dizziness	Y	N	M
Weakness	Y	N	M
Stroke / TIA	Y	N	M
Hematologic / Lymphatic			
Bruise easily	Y	N	M
Slow to heal	Y	N	M
Enlarged glands	Y	N	M
Eyes			
Wear glasses / contacts	Y	N	M
Blurred / double vision	Y	N	M
Eye disease or injury	Y	N	M
Glaucoma	Y	N	M
Allergies			
Food	Y	N	M
Latex	Y	N	M
Medicine	Y	N	M
Gastrointestinal			
Nausea / Vomiting	Y	N	M
Abdominal pain	Y	N	M
Rectal bleeding	Y	N	M
Blood in urine	Y	N	M
Kidney stones	Y	N	M
Other			
Skin infection ie MRSA	Y	N	M
Changes in hair or nails	Y	N	M
Rashes or itching	Y	N	M
Breast lump	Y	N	M
Breast pain or discharge	Y	N	M
Change in menstrual cycle	Y	N	M
Tuberculosis	Y	N	M
Cancer	Y	N	M
Chemotherapy or radiation	Y	N	M
HIV / AIDS	Y	N	M
Diabetes	Y	N	M
Blood clots	Y	N	M
Depression	Y	N	M
Insomnia	Y	N	M
Confusion or memory loss	Y	N	M
Do you smoke?	Y	N	M
Use tobacco products?	Y	N	M
Are you pregnant?	Y	N	M