pt:fit
910 Waukegan Road
Glenview, IL 60025

(p) 847.657.0881
(f) 847.657.0882

Patient Information:

Name: _____

Address _____

City _____ **State**_____ **Zip** _____

Phone: (PLEASE CHECK THE PREFERRED NUMBER FOR MESSAGES)

❍ HOME _____

❍ WORK _____

❍ CELL _____

What's the earliest/latest we can phone your home? _____

Email _____

Date of Birth: _____**Gender Identity:** _____

Social Security Number:_____

Date of injury (If applicable):_____ **Date last worked:**_____

Emergency Contact:

Name: _____

Relation: _____

Phone Number: _____

Insurance Information:

Primary insurance holder: _____

Date of Birth: _____

Employer Name: _____

Insurance Company: _____

Phone: _____**Fax:** _____

Insurance Plan Name: _____

ID number: _____ **Group Number:** _____

Referring Physician:

Name _____

Address _____

City _____ **State**_____ **Zip** _____

Phone:_____**Fax:**_____

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Patient Medical History

Please tell us about you:

Name: _____ **Age:** _____

Why were you referred to physical therapy?

Please describe how and when your injury occurred.

_____

_____

_____

In the last year have you undergone any surgical procedures? ❍ YES ❍ NO

In the last year have you been admitted to a hospital? ❍ YES ❍ NO

If yes, what hospital? _____

What was the condition/surgery that required hospitalization?

_____

_____

_____

Is this condition the reason you were referred for physical therapy? ❍ YES ❍ NO

Have you received any physical therapy treatment during the past year? ❍ YES ❍ NO

If yes, for what condition? _____

_____

Where was this treatment administered? _____

_____

Please tell us about your activities at work and at home: _____

_____

_____

_____

_____

Occupation: _____

Is the majority of your day spent: ❍ SITTING ❍ STANDING ❍ WALKING

At the present time, what are the most difficult tasks for you to perform?

AT WORK: _____

AT HOME: _____

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Patient Medical History (Continued)

What is the heaviest object you lift at work? _____

What is the weight of this object? _____

How many times do you lift object daily? _____

Have you been able to work? ❍ YES ❍ NO

If No: What was the last day you worked? _____

If you are unable to work at your regular job, do you expect to return to other work?

❍ YES ❍ NO

Have you received any special tests related to your injury/condition? ❍ YES ❍ NO

If yes, please specify: _____

Are you taking any medications? ❍ YES ❍ NO

If yes: what type and for what condition? _____

Are you taking any supplements? If yes: what kind? _____

_____

_____

_____

What is the heaviest object you lift at home? _____

What is the weight of this object? _____

How many times do you lift object daily? _____

What type of exercise activities are you currently doing, and how many times a week?

_____

_____

_____

What are your hobbies? _____

_____

_____

What are your goals for therapy? _____

_____

_____

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Patient Medical History (Continued)

Do you have a history of:

Seizures	❍ YES	❍ NO	**Cancer**	❍ YES	❍ NO
Stroke	❍ YES	❍ NO	**Falls**	❍ YES	❍ NO
Diabetes	❍ YES	❍ NO	**Unexplained weight loss**	❍ YES	❍ NO
Dizziness	❍ YES	❍ NO	**Night Sweats**	❍ YES	❍ NO
Exposure/Treatment TB	❍ YES	❍ NO	**Cough over 2 weeks**	❍ YES	❍ NO
Fever over 2 weeks	❍ YES	❍ NO			

Cardiovascular:

High Blood Pressure	❍ YES	❍ NO	**Heart Disease**	❍ YES	❍ NO
Pace maker	❍ YES	❍ NO			

Bowel:

Gas:	❍ YES	❍ NO	**Bloating:**	❍ YES	❍ NO
Diarrhea:	❍ YES	❍ NO	**Constipation:**	❍ YES	❍ NO
Food Allergies:	❍ YES	❍ NO	**Blood in Stool:**	❍ YES	❍ NO

Urogenital:

Urination Frequency: **During day:**_____ **During Night:**_____

Burning:	❍ YES	❍ NO	**Dribbling:**	❍ YES	❍ NO

Women's Health:

Are you now or is there a chance that you may be pregnant? ❍ YES ❍ NO

Length of menstruation cycle: _____

Age at first period: _____ **Date of last period:**_____

Hot Flashes:	❍ YES	❍ NO	**Night Sweats:**	❍ YES	❍ NO
Do you use birth control:	❍ YES	❍ NO	**Pain with intercourse:**	❍ YES	❍ NO

Number of Pregnancies: _____ **Number of full term:** _____

Type of Delivery: VAGINAL ❍ YES ❍ NO CESAREAN SECTION: ❍ YES ❍ NO

Episiotomy: ❍ YES ❍ NO

Complications: _____

_____

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Patient Medical History (Continued)

Men's Health:

Pain with ejaculation: ❍ YES ❍ NO **Pain with intercourse:** ❍ YES ❍ NO

Pelvic pain ❍ YES ❍ NO

Endocrine:

Average hours of sleep per night: _____

What time do you go to bed: _____

Is there any other information you think might help us with your recovery:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____
PATIENTS SIGNATURE

_____
DATE

_____
GUARDIAN SIGNATURE

_____
DATE

Reviewed with Patient:

_____
THERAPIST SIGNATURE

_____
DATE

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Release of Information

I hereby authorize pt:fit, llc to release to my insurance companies, employer insurance groups, health plans, Medicaid/Medicare program, or any intermediaries, or physicians in connection with a program of physical exercise, which may include pilates exercise, physical therapy, aerobic exercise, massage therapy, yoga and/or weight and resistance training (the "Program"), and any billing or collection agents of pt:fit, llc, any medical or financial records or other information concerning the Program to obtain reimbursement on mine or pt:fit, llc's behalf for the services provided to me by pt:fit, llc and the physicians associated with the Program. Further, I authorize pt:fit, llc to release any medical information concerning the Program to physicians and clinicians associated with the Program who are my healthcare providers. I may revoke my authorization and consent at any time for any reason providing written notice to pt:fit, llc. This authorization shall not conflict with any internal policy regarding release information, which will have priority. This authorization is not intended to allow the release of records regarding my treatment for services requiring a restricted release under State or Federal law.

MY SIGNATURE BELOW INDICATES THAT I HAVE READ AND UNDERSTAND THIS AGREEMENT AND AGREE TO BE BOUND BY IT.

_____
SIGNATURE

_____ _____
PRINT NAME DATE

Assignment of Benefits

I, the undersigned, authorize assignment of benefits directly to pt:fit, llc.

_____
PATIENT NAME

_____
PATIENT SIGNATURE

_____
BLUE CROSS BLUE SHIELD ID #

_____
BLUE CROSS BLUE SHIELD GROUP

_____
DATE

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Patient Cancellation and Payment Policy

Pt:fit, llc clients are seen by appointment only. Scheduling is based on a first come-first served basis. To receive the full benefit of your session, please arrive on time.

Cancellation Policy

Cancelling An Appointment With No Charge. To cancel an appointment with no charge we require a twenty-four (24) hour notice. This notice must be given directly to pt:fit, llc by calling 847-657-0881. Notice provided to a therapist is not sufficient.

$60 Cancellation Fee. If you call pt:fit, llc directly and cancel your appointment in less than 24 hour of the scheduled time, there will be a $60 cancelation fee.

Full Price Required. If you do not call to cancel an appointment, you will be charged the full price of the session.

Note that cancellation and no-show fees cannot be billed to your insurance company.

Payment Policy. For most clients, payment is due at the time of service. However, pt:fit, llc is under contract with BC/BS. If you are a patient of Gretchen Schmaltz with a prescription from your doctor, there is a $20 co-payment due at the time of service. Pt:fit, llc will bill BC/BS directly. Sometimes BC/BS will send the payment to you. We require that you send the payment along with the Explanation of Benefits within 10 days of your receipt of the check. Once we receive the check, we will bill you for the balance due or refund any overpayment. You will incur a 5% finance charge per month for overdue balances.

Please initial the method of payment that applies to you.

Payment is due at the time of service. _____
INITIAL HERE

My services will be covered by BC/BS. I will make a $20 co-payment at the time of service and I agree to sign checks received by me for pt:fit, llc services from BC/BS over to pt:fit, llc and mail them along with the Explanation of Benefits statement within 10 days of receipt of the check. I understand that there will be a 5% finance charge per month for outstanding balances. _____
INITIAL HERE

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Patient Cancellation and Payment Policy

Collection Action:

I, the undersigned, understand and agree that if collection action should become necessary for recovery of any monies due under services rendered or products purchased, I am responsible for any and all collection costs, court costs, and attorney fees. I also understand and agree that accounts with balances outstanding more than thirty days from the date of service or purchase will be charged a service fee of 5% per month of the outstanding balance, until the balance is paid in full.

By signing below, I agree to abide by the Cancellation and Payment Policies of pt:fit, llc.

CLIENT'S SIGNATURE DATE

pt:fit
910 Waukegan Road
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HIPAA Privacy Policy

In compliance with The Health Insurance Portability and Accountability Act (HIPAA), re:fit, inc. is informing you of your privacy rights. Please review the information carefully.

What is HIPAA? HIPAA is a law passed by Congress in 1996 to improve the efficiency and effectiveness of the healthcare system. It requires health care professionals to adhere to privacy and security standards in order to protect their patient's Personal Health Information (PHI). PHI is confidential information about a patient, including demographic information.

What are my rights under HIPAA? Under HIPAA you have a right to request the following as long as a request is made in writing to the attention of the Privacy Officer and applicable fees are paid. There is a possibility that your request may be denied. If your request is denied we will explain why it was denied in writing.

- You have a right to inspect and obtain a copy of your PHI. We will respond to your request within 30 days. In most cases your request will be honored and a copy of your PHI will be mailed to you.
- You have a right to request an amendment of PHI. If you feel that your PHI is inaccurate or incomplete, you may request an amendment to your PHI. We will respond to your request within 60 days. If we honor your request we will amend your PHI and notify you and applicable parties. We will deny your request if we determine your PHI to be correct or complete, if your request was not created by us, or if PHI is not available for inspection.
- You have the right to know what disclosure(s) of your PHI have been made. You have a right to request a listing of who your PHI was sent to, when it was sent, what content of your PHI was sent and for what purpose. We will respond to your request within 60 days. There will be no charge to you for an initial request. Additionally, your request may not include disclosures made for national security reasons, to law enforcement officials/correctional facilities, or disclosures made prior to April 14, 2003.
- You have a right to request confidential communications of PHI. We will honor all reasonable requests to keep communications confidential. A reasonable request is one that specifies an alternative address, gives other means of contact and provides detailed information on how payment will be handled.

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- You have a right to request restrictions on the use and disclosure of PHI, however we are not required to agree to your request. Your request must state specific restrictions requested and to whom the restrictions would apply.
- You have a right to receive a hard copy of this notice. This notice can also be accessed on our website www.refitinc.com.

How will pt:fit Use and Disclose PHI under HIPAA? HIPAA allows us to use and disclose your PHI for the purposes of Treatment, Payment and Healthcare Operations. We will specifically use and disclose your PHI to communicate with your physician and to, upon request, assist your insurance company with the processing of your claims. Additionally, we will use your basic demographic information to notify you of new services or facilities. Your authorization is not required for Use and Disclosure of PHI for the purposes of Treatment, Payment and Healthcare Operations. Listed are other instances in which Use and Disclosure of your PHI is allowed without your authorization.

Disclosure to those Involved in the Individual's Care when necessary, we will make a professional decision to disclose PHI to family members, close friends or other persons involved in and assisting in your care when you approve or when are not able or present to approve.

Uses and Disclosures Required by Law

As required by law we are required to use and disclose PHI for the following reasons:

- **Use and Disclose PHI for Public Health Activities** - Examples include: communicable diseases, sexually transmitted diseases, lead poisoning, Reyes Syndrome, etc., to public health officials.
- **Disclose PHI about Victims of Abuse, Neglect, or Domestic Violence** - Examples include: child abuse and neglect; an abused or neglected nursing home resident; a patient over 60 years old involved in elder abuse.
- **Uses and Disclosure of Health Oversight Activities** - We may use and release PHI to be used for audits, investigations, licensure issues, etc.
- **Disclosure for Judicial and Administrative Proceedings** - We may disclose limited PHI to the appropriate authorities as a result of a court order subpoena, discovery request, etc.

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- **Disclosure for Law Enforcement Purposes** - We may disclose reasonably necessary PHI to law enforcement officials to identify or locate a suspect, fugitive, material witness or missing person.
- **Uses and Disclosures Related to Decedents** - We may use and disclose PHI to a coroner or medical examiner and funeral directors as required by law.
- **Uses and Disclosures Related to Cadaveric Organ, Eye or Tissue Donations** - We may use and release PHI in order to facilitate organ, eye or tissue donations.
- **Uses and Disclosures to Avert a Serious Threat to Health or Safety** - We may use and release PHI to public health and other authorities required by law in order to prevent a serious threat to your health or safety.
- **Uses and Disclosures for Specialized Government Functions** - We may use and release PHI for military/veterans activities and national security/intelligence activities.
- **Use and Disclosure of PHI in Emergency Situations** - In the event of an eminent threat to the safety of a patient, we may disclose PHI to prevent or lessen the threat.
- **Uses and Disclosures of PHI for Marketing Purposes** – pt:fit will notify you of new services and facilities unless you specify otherwise. Unless you authorize such a disclosure we will not disclose your PHI for marketing purposes.
- **Uses and Disclosures of PHI for Research Purposes** – We do not use or disclose identifiable PHI for research purposes, unless you authorize such use and disclosure.
- **Uses and Disclosures requiring the Patients Authorization** - We must obtain your written authorization if we are interested in using and or disclosing your PHI for reasons other than treatment, payment and health care operations. You may revoke your authorization at any time.

What does HIPAA require of pt:fit? pt:fit must maintain the privacy of PHI, abide by the terms of this notice and provide patients with a revised notice, if necessary.

Where can I file a privacy complaint? If you feel your privacy rights have been violated, contact Loribeth Cohen at 847-657-0881. Or contact the regional Department of Health and Human Services at 312.886.2359 or visit their website.

You will not be penalized or otherwise retaliated against for filing a complaint.

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Contact Person

The name and address of the person you can contact for further information concerning our privacy practices is:

Loribeth Cohen
910 Waukegan Road
Glenview, IL 60025
847.657.0881

Effective Date

This notice is effective on or after September 1, 2010

Acknowledgement of Receipt of HIPAA Privacy Policy

pt:fit, llc reserves the right to modify the privacy policy outlined in the notice.

I HAVE RECEIVED A COPY OF THE HIPAA PRIVACY POLICY FOR pt:fit, llc

_____
PRINT NAME

_____
SIGNATURE

_____
DATE

_____
SIGNATURE OF PATIENT REPRESENTATIVE
(Required if the patient is a minor or an adult who is unable to sign this form.)

_____
RELATIONSHIP OF PATIENT REPRESENTATIVE TO PATIENT