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1659 W Hubbard Street
O:(312)489-8579 I F:(312)489-8430
Info@TheMovementGuildChicago.com

PATIENT REGISTRATION FORM

Last Name :	First Name :	Middle:	
Address:	City:	State:	Zip:
	DOB: (mm/dd/yyyy) Age:	Gender:	
Home Phone :	Cell Phone :	Work Phone:	
E-Mail Address:	Preferred Method of Contact: ☐Home ☐Work ☐E-Mail ☐Cell		
Reason for Appointment:	Which Side of the Body? ☐Left ☐Right	Date Symptoms Began:	

PHYSICIAN INFORMATION

Signing Physician :	Signing Physician Phone:		
Primary Care Physician:	Primary Care Phone:		
Address:	City :	State:	Zip:

REQUIRED IF LEAVING PHYSICIAN INFORMATION BLANK: I decline to provide the name of another treating healthcare professional or physician. SIGNATURE:

INSURANCE INFORMATION *(if using)*:

Insurance Carrier:	Member ID/Policy Number:
Group Number:	Policy Holder Name / DOB/ Relation:

HOW DID YOU FIND OUT ABOUT REAL PT?

- ☐ *I am a Former Client*
- ☐ *Website*
- ☐ *Yelp*
- ☐ *Personal Trainer:*
- ☐ *Google*
- ☐ *Family/Friend*
  - *Recommendation Name:* _____
- ☐ *Internet Search*
- ☐ *Doctor Recommendation*
- ☐ *Chiropractor Recommendation*
- ☐ *Special Event:*
- ☐ *Other:*

Patient/Guardian Signature: Date:

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Consent for Treatment

I voluntarily consent to receive treatment at REAL pt, LLC. I permit its employees and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand that this care may include an evaluation, testing and treatment. No guarantees have been made to me about the outcome of this care. I hereby authorize REAL pt, LLC to release information, verbal and written, contained in my medical record, and other related information to my insurance company, rehabilitation nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries, and all other related persons as it relates to my treatment and/or payment for services provided.

Patient/Guardian Signature _____ Date _____

Financial Responsibility

I understand that insurance coverage is not a guarantee of payment. I understand that I am ultimately responsible for services rendered by REAL pt, LLC. I will honor the REAL pt payment policy. All co-payments and patients that are selfpay are due in full at the time of service. Co-insurance and deductibles are the patient's responsibility. They will be invoiced once the Explanation of Benefits is provided by the patient's insurance carrier. Invoices are due 30 days after receipt. I authorize payments of benefits directly to REAL pt, LLC for services provided. REAL pt, LLC has the right to consult a collection agency if payment is past 90 days due. If any portion of the account balance exceeds 90 days the patient will be responsible for this amount plus interest of 1.5% per month, unless otherwise noted. I understand that I am financially responsible for payment of all services that are not paid by my insurance carrier. Should my account be referred to collection, I will be responsible to pay reasonable cost of collections including attorney fees. If I choose to be a self-pay patient I understand the fees are as agreed upon between myself and REAL pt.

Patient/Guardian Signature _____ Date _____

Cancellation Policy

REAL pt, LLC prides itself on providing its patients with dedicated time to meet your physical therapy needs and your schedule. Therefore, you agree to provide us at least 24 hours advance notice if you are unable to attend your scheduled appointment. If you do not cancel at least 24 hours prior to the scheduled start time of your appointment, you may be responsible for paying a cancellation fee of $100.00. If you do not show up for your scheduled appointment, you will be responsible for paying $125.00 for the appointment. All payments are nonrefundable. REAL pt reserves the right to reschedule an appointment as necessary upon reasonable notice to the patient.

Patient/Guardian Signature _____ Date _____

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PATIENT MEDICAL HISTORY

Name: _____

Diagnosis/Body part(s) you are being referred for:

_____

Dates Symptoms Began: _____

Please Check: ☐Work Injury ☐Motor Vehicle Accident ☐Other _____

Did this injury require surgery? ☐Yes ☐No

Kind of surgery and Date: _____

Are you taking any medications for this injury?

☐Yes ☐No

Please list all Medications:

_____

_____

Please check your PRE-INJURY level of function below:

☐0% ☐10% ☐20% ☐30% ☐40% ☐50%

☐60% ☐70% ☐80% ☐90% ☐100%

Please ccheck your CURRENT level of function below:

☐0% ☐10% ☐20% ☐30% ☐40% ☐50%

☐60% ☐70% ☐80% ☐90% ☐100%

Please describe the location of your pain:

_____

Please indicate which of these words, if any, describe your pain. Check all that apply:

☐Aching ☐Shooting
☐Burning ☐Throbbing
☐Sharp ☐Tingling

Rate your pain intensity on a scale of 0-10 (0 being no pain):
Current pain ___ /10 At Best ___ /10 At Worst ___ /10

Which activities increase your symptoms? Check all that apply:

☐Bending ☐Reaching ☐Squatting ☐Twisting
☐Driving ☐Reclining ☐Walking
☐Kneeling ☐Rising ☐Stairs
☐Lifting ☐Sitting ☐Standing
☐Other _____

What eases your symptoms?

☐Moist Heat ☐Ice Application ☐Medication
☐Rest ☐Change in position ☐Other

Normal Physical Work Activities:

_____

_____

Is your condition overall:

☐Improving ☐Getting Worse ☐Staying the same

Have you had any treatment of this current problem in the past?

☐Yes ☐No

Have you received any of the following tests for this problem?

☐X-rays ☐CT Scan ☐Bone Scan

☐MRI ☐EMG ☐Nerve Conduction Study

☐Other _____

Medical History Information: If you have/had any of the following conditions, please check and give approximate dates or indicate current. If it does not apply, please write N/A.

☐Arthritis _____
☐Asthma _____
☐Blood Pressure Problems _____
☐Broken Bones _____
☐Convulsions _____
☐Diabetes _____
☐Disabling Headaches _____
☐Disc Trouble _____
☐Fainting Spells _____
☐Heart Problems _____
☐Osteoporosis _____
☐Pacemaker Implantation _____
☐Paralysis or Muscle Weakness _____
☐Pregnancy _____
☐Spine Issues _____
☐Tumor or Cancer _____
☐Other _____

Please list ALL previous surgeries and the year performed regardless of body part:

_____

_____

_____

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MEDICAL RECORD PRIVACY INFORMATION

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our Policy on Medical Record Privacy

This notice will describe the way our practice will treat medical records we keep regarding your medical care. We are required to keep a record for you care, including your diagnosis, treatment, services you receive, and other information. We are required by law to protect your personal medical record by keeping it private and following certain rules that dictate whether and when we can use or disclose your information. This notice will inform you of these rules. It will also notify you of your rights and our obligations in our use and disclosure of your health in- formation. We are also required to give you notice, and to fol- low the terms of the notice that is currently in effect. We reserve the right to change this notice, and apply those changes to health information we currently have, as well as information we may receive in the future. If we change this notice, you will receive a new copy of this notice the next time you receive services from our practice. A copy of this notice will be on display in our office.

Understanding Your Health Record

Each time you visit Real PT, a record of your visit is made. Typically, this record contains your symptoms, examination, test results, diagnosis, treatment, and a plan for future care of treatment. This information, often referred to as your health or medical record, may serve as a:

- Basis for planning you care and treatment
- Legal document describing the care you received
- Means by which you or a third party payer (such as your insurance company or HMO) can verify that services billed were actually provided
- A source of data for medical research
- A source of information for public health officials charged with improving the health of Illinois and the nation
- A source of data for planning and marketing
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

You Have Rights Regarding Your Health Information

You have the right to:

- Request that we restrict the use or disclosure of your health information for treatment, payment, or healthcare operations (as described in this notice)
- Request that we restrict from disclosing information to family or friends
- Request how you would like us to communicate with you
- Inspect and copy certain health information, including most of your medical and billing records. This request must be made in writing to the Privacy Officer. A reasonable fee may be applied for copying, postage, or other expenses related to your request. We may deny your request to inspect and or copy your health information. If we do, another licensed health care professional will review your request and we will comply with the outcome of the review.
- Amend your health record as provided in 45 CFR 164,528
- Obtain an accounting of disclosure of your health information as provided in 45 CFR 164,528
- Obtain a paper copy of this notice upon request

NOTE:

We are not required to agree to your requests. To request restrictions or limitations, you must make a written request to the Privacy Officer. The request must tell us (1) what information you want to limit; (2) whether you want to limit the use of the information and or disclosure of the information; (3) to whom the limitation or restriction will apply.

Our Responsibilities

Real PT is required

to Maintain the privacy of your health information

- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we were unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the practice's Privacy Officer at 312-489-8579. If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the Office of Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office of Civil Rights.

The address for the OCR is listed below:

Office of Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

How We May Use and Disclose Your Health Information

We may use and disclose your health information for a number of purposes in connection with your medical care and in running our practice. The following lists a number of typical uses and disclosure within our practice. We will use your health information for the following:

Treatment

We may use your health information to diagnose your illness or injury, provide you with services, or refer you to another physician. We may disclose your health information to doctors, nurses, technicians, medical students, or other personnel who are involved with your care. We also may disclose your health information to people outside of our medical practice who may be involved in medical care, such as family members, clergy or others.

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Payment
We may give your health plan information regarding your diagnosis and treatment in order to be paid for your office visits, procedures, x-rays, or laboratory work. We may also provide information to determine whether your health plan pays for medical care you need, and whether we need to get authorization from the health plan before treating you.

Health Care Operations
We may use or disclose your information if we conduct quality assessment and improvement activities to ensure that our patients receive quality medical care. We may also use or disclose your information in training and evaluation of our physicians and other staff, or as part of a medical review, audit, or legal activities.

Appointment Reminders
We may use or disclose your information to contact you as a reminder that you have an appointment with our practice.

Individuals Involved in Your Care or Payment for Your Care
We may disclose your health information to a family member or friend who is involved in your medical care or who helps pay for your care. We may also tell your family or friends about your condition, for example, if you are admitted to the hospital or in the event of a disaster relief effort.

Public Health Risk
We may disclose your health information to report disease, injury or disability ; births and deaths; child abuse or neglect ; defects, recalls or problems with drugs, medical devices, or other products; to prevent or conditions. We may also notify authorities if we believe you have been the victim of abuse, neglect or domestic violence, if we are required by law to do so, or if you agree to the notification.

Health Oversight Activities
We may also disclose your health information to agencies authorized by law for audits, investigations, inspections, and licensure.

Law Enforcement
We may disclose your health information when the following circumstances apply:

- If you have incurred certain injuries or wounds that are legally required to be reported;
- In response to a court order, subpoena, warrant, summons, Investigative demands, or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if under certain limited circumstances;
- About a suspicious death that we believe may be the result of criminal conduct;
- About criminal conduct on our premises;
- In emergency circumstances to report a crime, its location, or information about the person who may have committed the crime. Coroners, Medical Examiners, and Funeral Directors As necessary to carry out their duties.

Specialized Government Functions
We may disclose your health information to release information to military command authorities, upon you separation or discharge from military service to authorized officials. We may also disclose your health information to the appropriate government officials when it is neces-sary to conduct intelligence or other national security activities authorized by federal law. In addition, we may release your health information if it relates to the protection of the Presidents of the United States or foreign heads of state. Finally, we may disclose certain information related to members of the armed services and foreign military services to the appropriate personnel.

Inmates
If you are an inmate of a correctional facility or under the custody of a law enforcement official, we may disclose your health information to the correctional institution or law enforcement official in order to provide you with medical services, protect you or others, or to ensure safety of the correctional facility.

Workers' Compensation for Work Related Illness or Injuries
We may disclose your health information in relation to workers' compensation or similar programs established by law that provides benefits for work-related illness or injuries.

Other Uses of Your Health Information
We may disclose your health information when required by federal, state or local law, for treatment alternatives or health related benefits/ services, organ and tissue donations, or to avert a serious threat to health or safety.

ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I received the Notice of Privacy Practices of Real PT

_____ _____
Patient / Parent or Guardian Signature Date

_____
Patient / Parent or Guardian Printed Name

Office Use Only:

_____ _____
Witness Date

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Credit Card Authorization

I, _____, hereby authorize REAL Physical Therapy to charge my credit/debit card for the portion of the services that are my responsibility. This includes any patient responsibility from services rendered (deductibles, co-payments, co-insurances) and/or fees incurred (cancellations within 24 hours of appointment or no-show appointments). I understand my card will be charged on a weekly basis for these amounts. I also understand that in the event my card declines, I will be required to provide a different method of payment. I will also be expected to pay for any previously unpaid charges resulting from the decline, in addition to the current charges. I understand that if my open balance with REAL Physical Therapy is not paid within 60 days of my last appointment, my card will be charged the full amount of the open balance.

Credit Card Number: _____

Expiration Date: _____ CVV Code: _____

Billing Address for Credit / Debit Card Listed Above:

_____

_____

Patient Name: _____ Date: _____

Patient Signature: _____