PATIENT INFORMATION

(Please complete both sides of form)

Date_____Clinic Location _____

Name_____
(First) (Last) (Middle)

Height_____Weight _____

Address_____Apt#_____

City_____ State_____Zip_____

Cell Phone_____Home Phone_____

Birth Date_____ Social Security No. _____

Email_____ Preferred Pronoun

Marital Status: ◯Married ◯Single ◯Other Sex:◯M ◯F

How did you hear of React Physical Therapy?

o I am a former patient
o Friend/Relative, Name: _____
o Social Media
o Magazine or Online Article _____
o Google/Internet Search
o React Physical Therapy Staff, Name: _____
o Doctor who wrote my prescription
o Other _____

PHYSICIAN INFORMATION

Referring Physician
_____Phone_____

Address _
_____Fax _____

Primary Care Physician _____ Phone _____

Address _____ Fax _____

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PATIENT HEALTH & MEDICAL HISTORY

Exercise Frequency:_____Exercise Type(s): _____

Do you smoke?_____How often? _____

Are you pregnant?_____If yes, # of weeks: _____

Do you have a pacemaker?_____Allergies:_____

Medications:

List all of the Prescription Medications or Over the Counter Drugs you are now taking (We can copy a detailed list if you have one):

_____

_____

Complaint:

What is your major complaint? _____

Start Date:_____Possible Cause: _____

Symptoms: _____

Previous doctors seen for complaint: _____

Previous treatment for complaint:_____How recent? _____

Symptom-Aggravating Factors: _____

Symptom-Relieving Factors: _____

Time of Day Symptoms are Best:_____Time they are Worst: _____

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PATIENT HEALTH & MEDICAL HISTORY

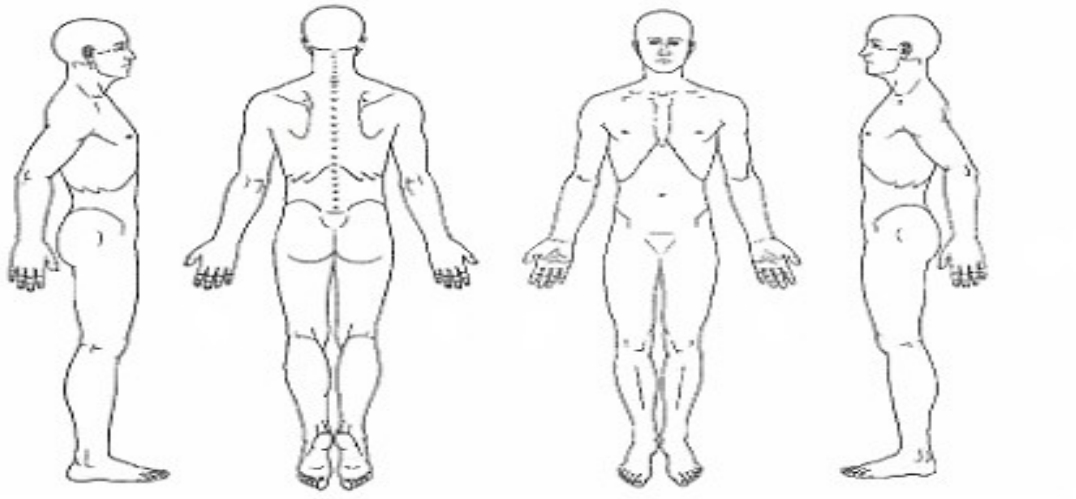
Current duration of Pain: ◯ Intermittent ◯ Constant ◯ With Certain Motions

Is your pain getting better or worse?_____ Have you had this injury before? _____

Type of Pain/Symptom (check all that apply):

☐ Dull ☐ Numbness ☐ Throbbing ☐ Shooting ☐ Sharp ☐ Achy
☐ Tingling ☐ Burning

CIRCLE AREAS OF PAIN BELOW



How would you rate your pain **right now**? 0=no pain and 10=worst possible pain

0 1 2 3 4 5 6 7 8 9 10

How would you rate your pain **at it's best**? 0=no pain and 10=worst possible pain

0 1 2 3 4 5 6 7 8 9 10

How would you rate your pain **at it's worst**? 0=no pain and 10=worst possible pain

0 1 2 3 4 5 6 7 8 9 10

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PATIENT HEALTH & MEDICAL HISTORY

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

- ☐ Changes in bowel or bladder function
- ☐ Headaches
- ☐ Weight loss/gain
- ☐ Dizziness/lightheadedness
- ☐ Numbness/tingling Shortness of breath
- ☐ Difficulty maintaining balance while walking
- ☐ Fever/chills/sweats
- ☐ Nausea/vomiting
- ☐ Pain at night
- ☐ Weakness/fatigue
- ☐ Difficulty swallowing
- ☐ Changes in appetite

Do you have any of the following **today**? (Check all that apply)

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Angina
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Clots
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Circulation Problems
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Osteoporosis
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ High/Low Blood Pressure
- ☐ Joint/Bone Infection
- ☐ Liver Problems
- ☐ Lung Issues
- ☐ Multiple Sclerosis
- ☐ Musculoskeletal Problems
- ☐ Pneumonia
- ☐ Stroke
- ☐ STD
- ☐ Tuberculosis
- ☐ Urinary Infection

Have you…	**Yes**	**No**	**If yes, explain briefly**
…been hospitalized in the last 5 years?	○	○	_____
…had any mental disorders?	○	○	_____
…had any broken bones?	○	○	_____
…had any strains or sprains?	○	○	_____
…ever used orthotics?	○	○	_____

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PATIENT HEALTH & MEDICAL HISTORY

Do you take minerals, herbs, or vitamins? If yes, please list _____

How is most of your day spent? ◯ Standing ◯ Sitting ◯ Other: _____

When was your last physical exam? _____

Please list past surgical history with approximate dates:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____

Please list any serious medical conditions for which you have been treated/hospitalized in the past:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____

During the past month, have you felt down, depressed, or hopeless? o Yes o No

During the past month, have you been bothered by having little interest or pleasure in doing things? ◯ Yes ◯ No

Is this something with which you would like help? (Circle)

◯ YES ◯ YES, BUT NOT TODAY ◯ NO

Do you have any other health issues or concerns that our staff should be made aware of?

_____

What are your goals for Physical Therapy?

_____

The above information I have supplied is complete, true, and correct to the best of my knowledge.

Signature of Patient or Legally Responsible Person _____

Date_____Printed Name of above _____

react PHYSICAL THERAPY

CONSENT AND RELEASE OF INFORMATION

1. **Consent For Treatment:** I consent to and authorize my physical therapist, occupational therapist and other healthcare professionals and assistants who may be involved in my care, to provide care and treatment prescribed by and/or considered necessary or advisable by my physician(s)/health care provider(s). I acknowledge that no guarantees have been made to me about the results of treatment.

2. **Access To And Release Of Health Information:** I understand that React Physical Therapy may document medical and other information related to my treatment in electronic and other forms and that such information will be used in the course of my treatment, for payment purposes and to support those who are caring for me. I authorize my clinician(s) and React Physical Therapy's administrative staff to contact other healthcare professionals that may have information related to my prior and current health conditions and treatment. I acknowledge that I have received React Physical Therapy's Notice of Privacy Practices and that it outlines how my health information will be used and disclosed and how I may gain access to and control my health information.

3. **Consent For Emergency Contact Information**:
   Person to contact in case of an emergency:

   Name/Relationship _____ **Telephone Number** _____

4. **Agreement To Receive Electronic Communication**
   I agree that React may communicate with me electronically at the email address below which may include, but shall not be limited to, appointments, general health reminders/information, and billing.

   _____ **(Patient initials)** I am aware that there is some level of risk that third parties might be able to read unencrypted emails and I am responsible for providing React Physical Therapy any updates to my email address.

   Email Address (PLEASE PRINT CLEARLY):

   _____@_____

5. **Consent To Text Usage For Appointment Reminders And Other Communication**
   Patients in our practice may be contacted by means of text messaging to remind you of an appointment and to provide general health reminders/information.
   If at any time I provide a mobile number at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information from the React Physical Therapy.
   _____ **(Patient initials)** I consent to receive text messages from React on my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive text messages will apply to all future appointment reminders/health information unless I request a change.

   The cell phone number that I authorize to receive text messages for appointment reminders and general health reminders/information is_____.

   The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

I can withdraw my consent to electronic communications and/or text usage by calling: 312-243-9350
By my signature below, I certify that I have read, understand, and fully agree to each of the statements in this document and sign below freely and voluntarily.

Patient/Parent Signature: _____ Date_____

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INSURANCE VERIFICATION

(Completed by React Physical Therapy Employee and Reviewed at Initial Examination)

Make Copies of Insurance Card and ID (Attach copy)

	In Network	Out of Network
Coverage		
Deductible/Amount Met		
Visit Limit		
Co-Pay		
Out of Pocket		

Representative Name _____

Case Number_____

Date Verified_____Verified By _____

Documentation Required? ◯ Yes ◯ No

Pre-certification Required? ◯ Yes ◯ No

As a courtesy, React Physical Therapy, verified your eligibility and benefits with your insurance company. The benefits quote provided by your insurance is outlined below. Please note, a quote of benefits is not a guarantee of benefits or payment. Final coverage determination will be made once your claim is processed. In the event your claim processes differently from the benefits we were quoted, the coverage and befit outlined in your explanation of benefits will supersede this quote.

Our policy is to collect all copayments at time of service unless other financial arrangements are made in advance. We welcome all patients to pay their deductible, copay and/or coinsurance payments at the beginning of each visit.

Every effort will be made by this office to have all services and procedures preauthorized, when required by your health insurance company.

ASSIGNMENT OF BENEFITS: I hereby assign to React Physical Therapy all my rights and claims for reimbursement under my health insurance policy. I agree to provide information as needed to establish my eligibility for such benefits.

Signature of Patient or Legally Responsible Person_____

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Benefit Summary and Estimated Patient Responsibility
(to be completed by React staff)

☐ **Patient is In-Network and covered at 100%**
I understand that my insurance plan covers 100% of the network-negotiated treatment costs I incur as a patient. Per a financial agreement with the clinic billing department, I agree to pay the full cost of my visits if my insurance deems my claim unpayable for any reason.
Patient or Parent/Guardian Signature_____

☐ **Patient has Medicare only OR In- Network Primary insurance only**
I understand that I am responsible for my $_____ deductible. After the deductible has been met in full, my insurance will cover _____% and I will pay _____% of the allowed amount.
Patient or Parent/Guardian Signature_____

☐ **Patient has Medicare and supplemental insurance**
Per a financial agreement with the clinic billing department, I acknowledge that I am responsible for my $_____ Medicare deductible and my $_____supplemental deductible. After the deductible has been paid in full, Medicare will cover 80% and my supplemental insurance will cover the remaining _____%.
Patient or Parent/Guardian Signature_____

☐ **Patient has an In-Network primary insurance and a secondary insurance**
Per a financial agreement with the clinic billing department, I understand that I am responsible for my $_____ deductible. Additionally, I am responsible for my secondary insurance deductible of $_____ after both have been satisfied the clinic agrees to accept my in-network secondary insurance coverage rate and I will pay _____% of the allowed amount.
Patient or Parent/Guardian Signature_____

☐ **Patient has an Out-of-Network Insurance**
I understand that React Physical Therapy is not contracted with my plan and upon request, they will send my claim to my insurance. I understand I will be responsible for paying my out-of-network deductible of $_____.
After my deductible is met, React will honor my In-Network copay of $_____ OR _____% co-insurance. I understand that I am still obligated to satisfy my Out of Network Out of Pocket Limit of $_____ before my insurance would begin to cover my services at 100%. Alternately, I can elect to forego billing my health insurance and opt for React's self-pay program.
Patient or Parent/Guardian Signature_____

Notice regarding Non-covered Services
I understand that certain services and product purchases are considered non-covered by insurance and I must pay for these services in full at the time of each visit. These services include but are not limited to products such as Therabands, exercise balls, bottled refreshments, massage, fitness programs etc.
Patient or Parent/Guardian Signature_____

react PHYSICAL THERAPY

FINANCIAL POLICY

Thank you for choosing React Physical Therapy as part of your wellness journey. We are committed to providing you with the highest quality health care. In order to assist us in upholding our quality standards, please read the following guidelines carefully.

Proof of Insurance For your protection, all patients must complete our patient intake forms before treatment. We must also obtain a copy of your driver's license and current valid insurance cards. If you do not present an up-to-date insurance and ID card, payment in full for each visit is required until we can properly verify your coverage.

Coverage changes It is your responsibility to inform us of any changes to your coverage. If your insurance changes, please notify us prior to your next visit so we can take the necessary steps to help you receive your maximum benefit coverage.

Verification of benefits As a courtesy, our office will verify your eligibility and obtain a quote of benefits directly with your insurance plan. Please note that a quote of benefits and/or authorization does not guarantee coverage or payment by your plan. Knowing your insurance benefits is your responsibility.

We highly recommend you also contact your insurance carrier and familiarize yourself with your coverage. If you have any additional questions regarding the quote, we provided to you, please contact your insurance company directly.

Co-insurance, co-payments and deductibles All co-payments must be paid at the time of service. Any amount we collect at the time of your appointment is an estimate of your expected patient responsibility and this amount is based on your quote of benefits. For your convenience, automatic payment deductions via a card left on file with us, may be used for balances owed and this option is available to all patients. We accept all major credit cards, personal checks, flex spending and health savings accounts for payment.

Please help us to assist you with managing your healthcare costs by paying your patient responsibility at each visit.

Booking Fee New patients wishing to treat and returning patients who have not been seen in over one year with David Reavy, founder/CEO, are subject to a non-refundable fee of $250. This charge is not billable to insurance and is in addition to the service charges that will be billed for the appointment.

Missed appointments It is very important to attend therapy consistently and to arrive promptly for your appointment. You may be rescheduled if you arrive more than 15 minutes late for a scheduled appointment. It is important to schedule appointments in advance and to acknowledge that appointment times given one week do not automatically follow through to the subsequent weeks. At least 24-hours notice is required to cancel or reschedule an appointment without being charged. A cancellation of less than 24-hours notice or not showing up for an appointment will result in a cancel/no-show charge of $50. Appointments scheduled with David Reavy, founder/CEO, are subject to a $75 charge. This fee will not be waived for anything less than reasons due to extenuating circumstances. WORKERS'S COMPENSATION PATIENTS: We Appreciate your full cooperation in attending all scheduled therapy sessions. We reserve the right to communicate with your case worker regarding missed appointments.

Patient Balances Any patients that fail to pay copayments at the time of appointment or via card on file, will not be able to schedule any further appointments until their balance is paid in full or a payment plan is arranged. If your balance is over 30 days past due from the date of service, you will receive a statement advising of the amount due to satisfy your account in full. Please be aware that if a balance remains unpaid after 90 days, we may refer your account to a collection agency and our office will provide you with a referral to an alternate practice. As a result, any interest or collections fees incurred will become your responsibility due to your delinquent payment.

Claims submission We will submit your claims and assist you in any way we reasonably can to help get your claims paid. From time to time, your insurance company may need you to supply certain information directly to them.
It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility as submitting a claim does not guarantee payment.

In- Network Insurance We participate in most insurance plans, including Medicare. If we are in-network with your insurance, accepting your insurance does not place all financial responsibilities onto this practice, and you will be held accountable for any unpaid balances by your plan.

Out of Network Insurance If we are out-of-network with your insurance plan, our practice will accept your in-network benefit, after you have satisfied any remaining Out of Network deductible required by your plan.

We will send your claim to your insurance for consideration and payment according to your plan coverage.

Due to the increasing popularity of high-deductible health plans, we understand that predicting your out of pocket medical expenses can be difficult and costly. We are pleased to offer our self-pay program to assist patients in taking control of the cost of treatment. Prior to treatment, you may request additional self-pay pricing information.

Workers' compensation cases are currently accepted in our practice, as long as we are able to verify your claim is open and active. At this time, we are unable to offer letters of protection. However, we will submit claims and obtain appropriate authorization on your behalf.

Motor vehicle accidents Valid motor vehicle insurance with your personal injury coverage (PIP) and/or health insurance must be provided. Please advise us of your policy's Med Pay amount, so we may better help you manage your benefit. Once your Med Pay is exhausted, we may then bill your health insurance for services. You are responsible for setting up subrogation with your insurance to ensure proper processing and payment of your claims. Please forward any payments for our services accordingly. Third party claims and liens may be accepted on a case by case basis.

Non-covered services Although we are able to submit claims to most insurance carriers, our services may not be covered by your specific insurance plan. Please be aware that if some – or perhaps all – of the services you receive are determined to be noncovered or not considered reasonable or necessary by Medicare or other insurers, you will then be responsible to pay for these services in full.

Being referred to our clinic by another physician does not necessarily guarantee that your insurance will cover our services. Please remember that you are 100 percent responsible for all charges not covered by your plan: your physician's referral and our verification of your insurance benefits are not a guarantee of payment.

If your health insurance company determines that a service is not reasonable and necessary, or that a particular service is not covered under the plan, your insurer will deny payment for that service.

Acknowledgement of Receipt

I, _____ , have read and understand the payment policy and agree to abide by its guidelines.

Signature _____ Name _____

Signature of the Patient or guarantor *Name of the Patient or guarantor (please print)*

Date of Signature ____ ____ ____

MM *DD* *YY*