CORE
fitness + physical therapy

2940 West 95th Street
Evergreen Park, IL 60805
708.422.0990
Fax 708.422.7130
www.corefitnesspt.com

Health History Information

Name_____ Date of Birth_____

Email_____ Next Physician Visit_____

Physician Name_____ Physician Phone _____

Emergency Contact Name_____ Emergency Contact Phone_____

How did you hear about CORE?

❑ Doctor_____ ❑ Website / Social Media ❑ Newspaper

❑ Friend_____ ❑ Other_____

Please list ALL allergies_____

_____

Please list ALL medications_____

_____

Please check ALL of the following conditions you now have or have had in the past.

❑ Alzheimers	❑ Epilepsy / Seizures	❑ Parkinson's disease
❑ Amputation	❑ GI Problems (reflux, IBS)	❑ Peripheral Neuropathy
❑ Arthritis OA/RA	❑ Head injury / Concussion	❑ Peripheral vascular disease
❑ Asthma	❑ Headaches / Migraines	❑ Psychiatric history
❑ Blood pressure (high/low)	❑ Heart conditions	❑ Raynaud's
❑ Cancer	❑ History of bone or joint fractures	❑ Recent hospital admission
❑ Circulation problems	❑ Incontinence Bowel or Bladder	❑ Skin disease
❑ CHF	❑ Infections disease (HIV, TB, etc)	❑ Sleep disorder (sleep apnea etc)
❑ COPD / Breathing problems	❑ Kidney disease	❑ Smoking / Tobacco use
❑ Current fracture	❑ Liver problems / Hepatitis	❑ Stroke / TIA / CVA
❑ Current pregnancy	❑ Lymphedema	❑ Surgery_____
❑ Depression / Anxiety	❑ Metal implants	❑ Thyroid disease
❑ Diabetes Type I or II	❑ Multiple Sclerosis	❑ Visual impairments
❑ Dizziness / Vertigo	❑ Neck or back pain	❑ Wound
❑ Durg / Alcohol addiction	❑ Osteoporosis / Osteopenia	❑ Other_____
❑ DVT (blood clot)	❑ Pacemaker / Defibillator	
❑ Fibromyalgia	❑ Paralysis	

Current Condition

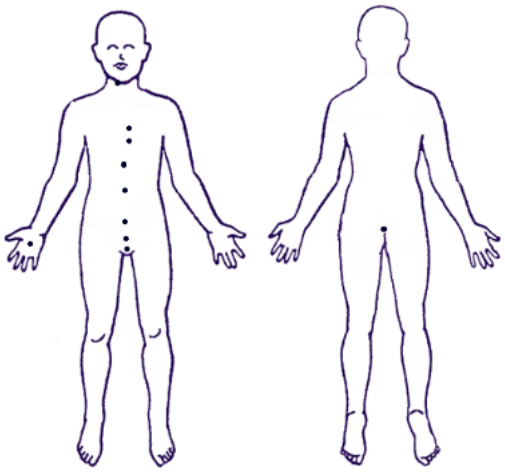
Date problem began_____

What is the primary problem, complaint or injury that brought you to therapy at this time?

_____

_____

Please shade the diagram where pain or symptoms are located:



Activities that **INCREASE** your pain or symptoms:
Activities that **DECREASE** your pain or symptoms:

If pain is part of your problem, please indicate your pain level:

No pain _____worst pain imaginable

0 1 2 3 4 5 6 7 8 9 10

Have you had: ❑ MRI ❑ X-ray ❑ CT Results_____

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Agreement for Services

Payment Terms

We strongly believe that part of a healthy working alliance involves staying current with your account at CORE Fitness and Physical Therapy. This enables us to pay your Physical Therapist for services rendered.

We are in-network with Blue Cross/Blue Shield only. If you are insured by BCBS, when you initiate services, our Billing Office will obtain a quote of benefits from Blue Cross/Blue Shield and will present this paperwork at your first visit (as a reminder, this is a quote of benefits, not a guarantee of payment). BCBS requires you to provide your insurance card and photo ID to avoid insurance fraud. If you are insured through any other carrier other than BCBS, we require a payment of $150 per visit. Most PPO plans will reimburse a portion of the cost for services received by an out-of-network provider. Our office can provide you with a self payment claim form with services rendered to submit to your insurance company. We also accept workers compensation and any patients who are involved in litigation due to an injury.

If your account has an outstanding balance, your portion of the services rendered are due at the time of service. We accept cash, check and credit card. We cannot accept Manna for insurance payments. Future appointments will be scheduled as long as your account is current.

Please see the following Credit Card Payment Authorization Form

Missed Appointment or Late Cancellation Fee

Missed appointments cannot be billed to your insurance. You will be charged $50 for appointments missed or cancelled without 24-hour notice. These charges must be paid at the next appointment or all future appointments will be cancelled.

There will be a $25 for returned checks.

If you have any additional questions or concerns, please contact our office manager at 708-422-0990.

Patient Signature_____ Date_____

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Release and Indemnification Agreement

I have requested the services of Core Fitness & Physical Therapy in connection with a program of physical exercise, which may include Pilates exercise, physical therapy, aerobic exercise and/or weight and resistance training (the "Program").

I am aware that the Program may involve certain risks of injury, and that I, rather than Core Fitness & Physical Therapy, control the nature and content of the Program. I have been examined by a physician prior to commencing the Program. In consideration of Core Fitness & Physical Therapy's services in connection with the Program, I assume the risk of any and all accidents, illnesses and injuries of any kind, which may be sustained by me by reason or in connection with my Program.

In addition, I agree that, to the fullest extent allowed by law, neither Core Fitness & Physical Therapy nor any of its owners, agents employees, personal representatives, successors or assigns shall be liable or responsible for or on account of any such accident, illness or injury, and I release, discharge, and absolve Core Fitness & Physical Therapy and its owners, agents, employees, personal representatives, successors or assigns from any and all losses, liabilities, damages, costs and obligations (or actions or claims in respect thereof) (including reasonable counsel fees), which they may suffer or incur, as such loses, liabilities, damages, costs or obligations (or actions or claims in respect thereof) arise out of or are based upon or are in any way connected with my Program.

This Agreement shall be binding upon my heirs, legatees, personal representatives, successors and assigns.

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

Print Name_____

Signature_____

Date_____

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Notice of Privacy Practices Receipt

Uses and Disclosures

I acknowledge that I have received and reviewed a copy of the Core Fitness & Physical Therapy STATEMENT OF PRIVACY that became effective January 22, 2012 which describes how health information about me or my child may be obtained, used and disclosed and how I can get access to this information.

By signing this form, I consent to Core Fitness & Physical Therapy use and disclosure of protected health information about me/my child for treatment, payment, operations and reporting as described in the Notice of Privacy Practices. I have the right to revoke this consent, in writing, except where disclosures authorized by prior consent have already been made.

Name of Patient_____

Signature of Patient_____

Signature of Guardian (if patient is under 18 years of age)_____

Date _____

OFFICE USE ONLY

I attempted to obtain the client's, parent's or guardian's signature in acknowledgment of the STATEMENT OF PRIVACY, but was unable to do so as documented below:

Date_____ Initials_____

Reason_____

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Release of Information

I hereby authorize Core Fitness and Physical Therapy 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 and/or weight and resistance training (the "Program"), and any billing or collection agents of Core Fitness and Physical Therapy, any medical or financial records or other information concerning the Program to obtain reimbursement on my behalf for the services provided to me by Core Fitness and Physical Therapy and the Physicians associated with the Program. Further, I authorize Core Fitness and Physical Therapy 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 Core Fitness and Physical Therapy. This authorization shall not conflict with any internal policy regarding release of information, which will have priority. This authorization is not intended to allow the release of records regarding any 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.

Print Name_____

Signature_____

Date_____

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Financial Policy

Welcome to our office! We are committed to providing you with the best possible care. If you have medical insurance, we are happy to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our financial policy. Payment, co-payment, deductibles, and coinsurance for services are due **each visit** for charges incurred up through your last visit. We accept cash, checks and all credit cards for payment. **Please understand that you are financially responsible for all charges, whether or not they are paid by Insurance.**

PLEASE READ CAREFULLY:

1. Your insurance is a contract between you, your employer and your insurance company. We are not a part to that contract. As a courtesy to our patients, we will bill your insurance carrier; however, we cannot guarantee payment in a timely manner. If for any reason, any portion of a bill is not paid by your insurance within 60 days from the date of service, you agree to make arrangements for prompt payment.
2. Any returned checks with be subject to a NSF fee of $25.00 which will be due at the next visit.
3. We have a 24 hour cancellation policy. If you cancel within the 24 hour period, or miss an appointment, our account will be charged a $50 fee.
4. Accounts that are past due will incur a finance charge at the rate of 10.5% annually.
5. Please see our credit card on file policy on the next page

Again, our relationship is with you, not your insurance company. We realize that financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact our billing department promptly for assistance in the management of your account. If you have any questions about the above information or any uncertainty regarding insurance coverage, please don't hesitate to ask as we are here to help you.

I herby understand the above financial policy and agree to abide by it.

Patient Name_____ Date_____

Patient Signature_____ Date_____

(If patient is under the age of 18)
Parent/Legal Guardian Signature _____ Date _____

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2940 W. 95TH STREET
EVERGREEN PARK, IL 60805
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Credit Card Recurring Payment Authorization Form

Please complete the information below:

I, _____ authorize CORE FITNESS AND PHYSICAL THERAPY to
(FULL NAME)
process payment on my Visa, MasterCard, American Express or Discover Card for services and/or for any balance due that has not been paid 30 days after it is received. I also authorize Core Fitness and Physical Therapy to process payment for my copayment at each visit. I understand that if the appointment is missed or I do not follow the cancellation policy as specified, Core Fitness and Physical Therapy is authorized to charge my credit card $50 per occurrence.

Patient Name_____

Billing Address_____ Phone#_____

City, State, Zip _____ Email _____

Account Type: Visa MasterCard Amex Discover

Cardholder Name _____

Account Number _____

Expiration Date _____

CVV (3 digit number on back of Visa/MC, 4 digits on front of AMEX) _____

SIGNATURE _____ DATE _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the business in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. This payment authorization is for the type of bill indicated above. I certify that I am an authorized user of this credit card and that I will not dispute the scheduled payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form.