Medical History

Patient: , - **Today's Date:**

General Information

1. Is this injury related to? ☐ Work ☐ Car Accident ☐ Other Liability/Potential Lawsuit ☐ Not Applicable

2. Do you have a Primary Care Physician / Family Doctor? ☐ No ☐ Yes
   If yes, have you had an appointment with him / her in the last 12 months? ☐ No ☐ Yes

3. Race/Ethnicity (Please select one):

☐ Caucasian (White) ☐ Hispanic or Latino Origin ☐ Eskimo/Inuit

☐ African American ☐ Asian ☐ Native American

☐ Other ☐ Declined

Please Mark One Box For Each Item	No	Yes Under a Year	Yes Over a Year	No Answer / Invalid	**Please Mark One Box For Each Item**	No	Yes Under a Year	Yes Over a Year	No Answer / Invalid
Smoking (including smokeless tobacco)	☐	☐	☐	☐	Sexual dysfunction	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	Bladder / bowel problems	☐	☐	☐	☐
Heart condition	☐	☐	☐	☐	Groin numbness	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	Arthritis	☐	☐	☐	☐
Chest pain	☐	☐	☐	☐	Osteoporosis	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	Psychological condition	☐	☐	☐	☐
Kidney condition	☐	☐	☐	☐	Seizures	☐	☐	☐	☐
Blood clot / DVT	☐	☐	☐	☐	Dizziness / faintness	☐	☐	☐	☐
Breathing difficulties / asthma	☐	☐	☐	☐	Ringing in ears	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	Allergy to latex (gloves)	☐	☐	☐	☐
Difficulty swallowing	☐	☐	☐	☐	Other allergy	☐	☐	☐	☐
Circulation / vascular problems	☐	☐	☐	☐	Head injury	☐	☐	☐	☐
Peripheral neuropathy	☐	☐	☐	☐	Obesity	☐	☐	☐	☐
Unexplained weight loss	☐	☐	☐	☐	Chronic pain / fibro / headaches	☐	☐	☐	☐
Double vision	☐	☐	☐	☐	Fractures	☐	☐	☐	☐
Night sweats / night pain	☐	☐	☐	☐	Infection	☐	☐	☐	☐
Metal Implants	☐	☐	☐	☐	Fever / nausea	☐	☐	☐	☐
Pacemaker	☐	☐	☐	☐	Are you pregnant?	☐	☐	☐	☐

	No	Yes	If yes, please specify the condition
Infection Disease	☐	☐	
Neurologic Condition (MS / Parkinson's)	☐	☐	
Pediatric Developmental Condition	☐	☐	
Skin Disease	☐	☐	
Spinal Cord Injury	☐	☐	
Degenerative Joint Disease	☐	☐	☐ Spine ☐ Upper Extremity ☐ Lower Extremity

Medical History

Patient: **Today's Date:**

Patient Medication List

Please list ALL medications (including prescription, over-the-counter, vitamins, dietary or nutritional supplements) which you may be taking routinely and/or on an as needed basis.

Medication	Dosage	Frequency	Route of Administration

Notice of Financial Responsibility

Patient Name:	Case ID:	Date:

Primary Insurance

We are _____ Network with your insurance plan.	Ins Plan:		
Policy ID:	Group ID:	Insured Name:	Insured Date of Birth:

If worker's comp / auto:

Date of Injury:	Claim:	Employer:	Adjuster:
SSN:	Accident State:		

If your insurance plan has a deductible:

Initials

Your deductible is **$**_____.

You have met **$**_____ of your deductible.

If you have not met your deductible:

Your insurance **requires** payment towards your deductible. We will take a payment **TOWARDS** that deductible at each visit. We require a payment of **$**_____ at each visit. Please understand that this is just a payment towards your deductible. Since we are contracted with your insurance plan, we are **REQUIRED** to collect the full deductible amount that is applied to the services you receive.

You will receive a billing statement for the difference between the payment made upfront and the amount your insurance allows for each visit.

If/When you have met your deductible:

Your insurance requires a co-payment of **$**_____ per visit. We will collect this amount at every visit.

Your insurance **requires** a co-insurance per visit. You are responsible for a co-insurance of _____**%** per visit. We require a payment of **$**_____ **TOWARDS** that co-insurance per visit. This payment will not be the entire co-insurance owed, but a low estimate of patient responsibility.

We will not know your full co-insurance amount until your insurance begins to pay on your claims; therefore, you will receive a billing statement for the difference between any payments made upfront and the actual amount due.

Initials

Insurance Limitations: ** This information is based on the insurance database and may not be up to date pending unprocessed claims. *

Your total out of pocket maximum is **$**_____ per year. You have met **$**_____ of your total out of pocket maximum to date.

Your insurance limits the amount of therapy that will be covered per year. Your insurance allows **$**_____ for therapy each benefit year.

Your insurance limits the number of visits of therapy you are allowed each year. Your insurance allows _____ therapy visits each benefit year. You have used _____ of those visits to date.

Your insurance requires pre-certification and has authorized _____ visits.

It is the responsibility of the patient to contact the insurance carrier to confirm OOPM, visit limitations, & authorization requirements.

Secondary/Tertiary/Supplemental Insurance:

Initials

We will submit charges for your visits to your primary and subsequent insurance companies. We may not collect a payment at this time. Depending upon how your insurance plan processes the claim, you may receive a bill for the balance that they do not cover.

We are _____ Network with your insurance plan.	Ins Plan:		
Policy ID:	Group ID:	Insured Name:	Insured Date of Birth:

Special Notes:

Initials

If you are not insured or your insurance is not contracted with our company, you will be responsible for $_____ per visit.

Please take notice that ATI assume no liability for any benefit information that is misquoted by your insurance carrier. It is ultimately your responsibility to be aware of your insurance coverage, limitations, and terms and conditions of your policy. Benefits and verification are performed as a courtesy. ATI cannot be responsible for any information that is obtained directly from your insurance carrier that is later deemed inaccurate. If additional treatment is necessary beyond your policy visit limits or dollar amount, we may consider alternative payment options.

This Notice of Financial Responsibility has been clearly explained to me. I have also read the information above and understand that I am responsible for payment of therapy services not covered by my insurance policy.

x _____ x _____

Patient/Guardian Signature Date Front Office Signature Date

_____

Relationship to Patient

Notice & Consent to Treat

Patient: , - **Today's Date:**

NOTICE OF PRIVACY PRACTICES

Acknowledgement of Receipt

By signing this form, you acknowledge that you have been offered a copy for review of ATI's Notice of Privacy Practices which is prominently displayed in the clinic and available on our website. This Notice of Privacy Practices provides information about how we may use and disclose your protected health information. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice and if you have any questions about our Notice of Privacy Practices, please contact our Privacy Officer at (630) 296-2222.

X_____ X_____
Patient/Guardian Signature Date

_____
Relationship to Patient

GENERAL CONSENTS AND ACKNOWLEDGEMENTS

1. I consent to and hereby authorize ATI Physical Therapy ("ATI"), through its appropriate personnel, agents and affiliates to perform the evaluation, care and treatment procedures that are deemed necessary by my physician(s) and other healthcare providers (collectively my "Care"). I understand that no warranties or guarantees have been made to me about the outcome of my Care.
2. I understand that ATI works with accredited academic institutions, through clinical affiliations, to provide healthcare professionals in training with hands-on patient care experiences and opportunities to apply learned skills to actual patient care. I further understand that such healthcare professionals in training may be involved in my Care.
3. I understand that ATI will not be responsible for the loss, destruction or theft of any of my personal property. I take full responsibility for, and release ATI from, any and all responsibility and/or liability for the loss, destruction or theft of my personal property at, or in the vicinity of, any ATI location or clinic.
4. I understand and acknowledge that ATI may lease or license real estate, equipment or other personal property (collectively "Leased Property") from third parties to perform the evaluation and treatment procedures that are deemed necessary by my physician and therapist in the treatment of my condition. In consideration of being permitted to make use of and/or have access to the Leased Property, I do hereby, on behalf of myself, on behalf of any minor or other person for whom I have requested such evaluation and treatment procedures ("Minor"), on behalf of my heirs, successors and assigns, and on behalf of such Minor's heirs, successors and assigns release and forever discharge any and all direct or beneficial owners of the Leased Property and their respective successors, related entities, directors, officers, employees, and agents (collectively, "Releasees") from, and hereby waive and release, any and all claims, demands, actions, and causes of action whatsoever arising out of or in any way related to any loss, damage, or injury, including death, that may be sustained by me and/or such Minor in, on, upon, in connection with or while making use of the Leased Property, regardless of whether any such loss, damage, or injury is caused by the active or passive negligence of the Releasees or otherwise and regardless of whether any such liability arises in tort, contract, strict liability or otherwise, to the fullest extent allowed by law. This paragraph **does not release any claims, demands, actions, and/or causes of action against ATI.**
5. I understand that I am not permitted to take pictures or make video or audio recordings at any ATI location or clinic or of my care, other patients or ATI personnel.
6. I understand that to ensure that patient inquiries are handled promptly, courteously, and accurately, some of the phone calls between ATI (or any of its affiliates, agents, assigns and service providers) and me (or anyone I have authorized to speak with ATI) may be monitored and/or recorded.
7. I understand and consent that ATI may from time to time make calls and/or send text messages to any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me and/or the account holder. I understand and consent that the manner in which these calls or text messages are made may include, but is not limited to, the use of prerecorded/artificial voice messages and/or automatic telephone dialing systems. I understand that I am not required to agree to this provision as a condition of receiving services and that my consent may be revoked at any time.
8. I understand and consent that ATI may send emails to me at any email address provided to ATI and/or use other electronic means of communication to the extent permitted by law. I understand that I am not required to agree to this provision as a condition of receiving services and that my consent may be revoked at any time.
9. I understand and acknowledge that my appointment times are scheduled in accordance with availability of professional staff. I understand that my appointment may be rescheduled by ATI if I arrive more than 15 minutes late. I also acknowledge that ATI requires 24 hours' advance notice of cancellation and that ATI reserves the right to charge a $40.00 cancellation fee if I fail to cancel an appointment at least 24 hours in advance.

X_____ X_____
Patient/Guardian Signature Date

Communication Preferences

Patient: , - **Today's Date:**

Consent to Communicate to Others

I hereby authorize ATI, through its appropriate personnel, to communicate with _____, my (circle one) **husband / wife / mother / father / son / daughter / significant other / friend** regarding billing and payment for services rendered on my behalf. I understand that ATI will attempt to verify the identity of those I authorize to communicate regarding billing and payment by way of seeking confirmation of the answers to at **least 2** of the following questions:

1) **Patient's mother's maiden name is _____.**

2) **City in which the patient was born _____.**

3) **Birthday of the patient is _____.**

4) **Name of patient's current pet is _____.**

5) **Zip code of the patient's mailing address is _____.**

☐ **I wish to decline authorization for others to communicate with ATI on my behalf.**

X_____ X_____
Patient/Guardian Signature Date

_____
Relationship to Patient

Referral Intake Information

Patient: **Today's Date:**

General Information

Account # :		**SSN:**		**Clinic Location # :**	
Name:					
Cell Phone:		**Home Phone:**		**Work Phone:**	
Address:					
City:		**State:**	**Zip:**	**Birth Date:**	
Employer:		**Employer Address:**		**Employer Phone:**	
Refer MD:		**Refer MD Fax:**		**Refer MD Phone:**	
Attorney:		**Attorney Fax:**		**Attorney Phone:**	

Date of Injury/Other Accident - Potential Lawsuit?	**Work Related?**	**Auto Related**	**Acct Type/Description**

Injury/Diagnosis	**Script Date:**	**Surgery Date:**

Emergency Contact:		**Relationship:**	
Emer. Contact Phone:			

ALL PATIENTS:
Therapy Services:
Have you ever had **ANY** therapy services elsewhere?

If so, when were the services? _____ Have you been discharged? _____

MEDICARE PATIENTS ONLY:
Home Health:
Is anyone coming to your home to provide healthcare services? _____ Nurse? _____ Home Health Aide? _____ Therapy Services? _____

If so, when? _____ Have you been discharged? _____

Front Office Initials: _____ **Patient Initials:** _____