PHYSICAL THERAPY & REHAB NET, INC.

Patient Information Form

Name: _____

Social Security #: _____ Date of Birth: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email address: _____

Home Address: _____ City: _____ Zip Code: ___

Spouse's Name: _____ Phone #: _____

Nearest Relative not living with you: _____ Phone: _____

Nearest friend not living with you: _____ Phone: _____

Primary Care or Referring Physician: _____ Phone: _____

Doctor: _____ Phone: _____

Whom may we contact in the case of an emergency? _____ Phone: _____

Whom may we thank for referring you to us? _____ Phone: _____

Did you sustain an injury at work?

Y N

Are you covered under an employer or union policy?

Y N

Are your injuries accident related?

Y N

Is your spouse or other family member employed?

Y N

Are you currently employed

Y N

Do you have a secondary insurance policy?

Y N

Have you ever served in the military?

Y N

Are you covered under any other health care plan?

Y N

Have you made any changes to your choice of Medicare options in the last open enrollment period?

Y N

Are you enrolled in a Medicare Advantage Plan?

Y N

I am a new patient to this practice and am in a pre-existing provision with my insurance carrier.

Y N

Who is responsible for this bill? _____

PHYSICAL THERAPY & REHAB NET, INC.

I have received services by another provider for the condition for which I seek treatment today and I will promptly disclose any necessary information to my insurance carrier necessary to resolve any issues they may have. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

Signature:_____ Date: _____

Assignment of Benefits Form

Practice Name: Physical Therapy & Rehab Net, Inc. Date: _____

Address: 11240 S. Western Avenue Patient: _____

City, State, Zip: Chicago IL. 60643 ID#: _____

Phone: 773-779-1111 Group#: _____

I, _____, understand that services rendered to me by **Physical Therapy & Rehab Net, Inc.** are my financial responsibility and that the provider will bill my insurance company _____, as a courtesy. I authorize my insurance company to pay my benefits directly to **Physical Therapy & Rehab Net, Inc.** and I understand that I will be fully responsible for any outstanding balance on my account. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee and I haves agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

I have been given the opportunity to pay my estimated deductible and coinsurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by _____(insurance company).

I authorize the provider to release any information necessary to adjudicate the claim, and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim.

I also understand that should my insurance company send payment to me, I will forward the payment to **Physical Therapy & Rehab Net, Inc.** within 48 hours. I agree that if I fail to send the payment to **Physical Therapy & Rehab Net, Inc.** and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies. In the event patient receives any check, draft or other payment subject to this agreement, I will immediately deliver said check, draft or payment to provider. Any violations of this agreement will, at provider's election, terminate patient charge privileges with provider and bring any balance owed by patient to provider immediately due and payable.

To avoid this additional cost and inconvenience, should the insurance company forward payment to me, I authorize **Physical Therapy & Rehab Net, Inc.** to facilitate payment utilizing the credit card number on file to resolve the balance. A photocopy of this Assignment shall be considered as effective and valid as the original.

I authorize **Physical Therapy & Rehab Net, Inc.** to initiate a complaint or file appeal to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

Dated_____ Witness _____

_____ _____

Signature of policyholder Patient or Guardian

Excellcare
Physical Therapy

(773) 779-1111
contact@excellcarept.com
www.excellcare.net
11240 S Western Ave,
Chicago, IL 60643

By initialing the below statements, the patient agrees to the following:

Patient's Name_____

Initials

_____ Regular attendance is **Mandatory** for successful rehabilitation.

_____ Patient failure to keep regularly schedule appointments as prescribed for the approved treatment plan may cause less than optimal expectations for full recovery.

_____ Co Pays/Co Insurance (if applicable) will be collected at each treatment visit.

_____ If you are unable to attend your schedule appointment, you must call the office at least one hour before your appointment time.

_____ If you are feeling increased soreness or pain (which is normal with new activities) you are still required to report to physical therapy so the therapist may assess the problem and if necessary, adjust your course of treatment.

_____ If you don't call or come in for a regular schedule appointment, your physician will be contacted and you may be discharged for noncompliance. A No call, No Show fee will be assessed ($40.00/visit).

_____ Noncompliance for WC patients will be reported to your employer, Workers' Compensation carrier and/or insurance carrier and may affect your Workers' Compensation benefits.

_____ _____

Patient's Signature Date

_____ _____

Excellcare P.T. Date

Excellcare
Physical Therapy

(773) 779-1111
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11240 S Western Ave,
Chicago, IL 60643

Coronavirus and physical therapy at Excellcare

Physical therapy is deemed an essential service, and it is important that we continue to offer care to our patients in a safe environment.

The following are our policies made to deliver a safe and healthy treatment experience:
-We require that all physical therapists and patients wear PPE, to include face masks covering nose and mouth in the clinic at all times.
-We sterilize all clinic surfaces with medical-grade disinfectants immediately after use.
-We screen all patients, clinicians for potential Covid-19 exposure.
-We limit the number of people in the clinic

Checklist before treatment/entering the clinic:

I have not shown any symptoms (coughing, sore throat, fever) in the last 14 days

I have not been in close contact with anyone who has had symptoms or has tested positive for Covid-19 in the last 14 days

I have not travelled to any of the states included in Mayor Lightfoot's travel ban, including any states and territories listed on the city of Chicago's website within the last 14 days

If you have answered yes to any of these questions, we ask that you reschedule your visit after a 14 day quarantine or show a negative Covid-19 test result.

X_____

PAST MEDICAL HISTORY

Excellcare Physical Therapy

Patient Name: _____ Date: _____

Are you working? Y N Employer Name: _____

Employer Tel. _____ Ocupation: _____

Date of Next Doctor's Visit: _____ Date of Injury/Onset: _____

Have you ever had these symptoms before? Y N

Check all that apply:

Work related injury___ Recurrence of previous____ Injury relate4d to failling____

Motor Vehicle Accident___ Injury related to lifting_____ Other____

Cause Unknown____ Athletic/recreational injury____

Have you had a related surgery? Y N

Circle all that apply:

Diabetes	Y	N	Allergies to Aspirin	Y	N
Chest Pain	Y	N	Allergies to Heat	Y	N
High Blood Pressure	Y	N	Allergies/Poor tol. to cold	Y	N
Heart Disease	Y	N	Latex Allergies	Y	N
Heart Attach	Y	N	Hernia	Y	N
Heart Palpitations	Y	N	Seizures	Y	N
Pacemaker	Y	N	Metal Implants	Y	N
Headaches	Y	N	Dizziness/Fainting	Y	N
Kidney Problems	Y	N	Recent Fractures	Y	N
Are you pregnant?	Y	N	Surgeries	Y	N
Cancer	Y	N	Skin Abnormalities	Y	N
Osteoporosis	Y	N	Hypoglycemia	Y	N
Bowel/Bladder Abnormalities	Y	N	Nausea/Vomiting	Y	N
Urine/Leakage	Y	N	Ringing in your ears	Y	N
Asthma/Breathing Difficulties	Y	N	Rheumathoid Arthritis	Y	N
Liver/Gallbladder Problems	Y	N	Other_____		
Smoking	Y	N	_____		
Stroke/CVA	Y	N			

Is there anythig else regarding your past medical history that we should know about?

_____

_____

_____

_____

_____