Praxis Physical Therapy and Human Performance
935 Lakeview Parkway Suite #195 • Vernon Hills, IL 60030 • Phone: 847-247-7200 • Fax: 847-247-4340

Returning Patient
Medical Registration Form (Page 1)

Welcome to our Office:
By completing this patient information form, you will help us to serve you more efficiently. Should you have any questions concerning our professional services or office procedures, please ask.

PLEASE PRINT – COMPLETE ALL INFORMATION:

Patient Name: _____ Date: _____

Home Address: _____

City: _____ Zip: _____ Home Phone: _____

Cell Phone: _____

Date of Birth: _____/_____/_____ Age: _____

Please complete any sections that have changed since your last visit:

Marital Status: Single____ Married____ Separated____ Widowed____ Divorced____

Name of Spouse (or parents of child): _____

Occupation: _____ How Long: _____ Work Phone: _____

Employer (patient or parents): _____

Work Address: _____

Insurance Information:

Is your insurance information the same since your last visit? YES _____NO_____ If NO, please complete the following:

Insurance Company: _____ Member I.D. #: _____ Group #: _____

Name of Policy Holder: _____ Policy Holder D.O.B.: _____ Relationship: _____

Referring Physician: _____

Address: _____ City: _____

Signature: _____ **Date:** _____

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Returning Patient Medical Registration Form (Page 2)

PLEASE INDICATE IF ANY OF THE FOLLOWING APPLY TO YOU. PROVIDE FURTHER INFORMATION ON THE LINE:

Diabetes	Yes	No	_____	Stroke	Yes	No	_____
Chest Pain	Yes	No	_____	Seizures	Yes	No	_____
Heart Disease	Yes	No	_____	Metal Implants	Yes	No	_____
Pacemaker	Yes	No	_____	Dizziness	Yes	No	_____
Headaches	Yes	No	_____	Fractures	Yes	No	_____
Kidney Problems	Yes	No	_____	Skin Allergies	Yes	No	_____
Are you pregnant	Yes	No	_____	Nausea/Vomiting	Yes	No	_____
Cancer	Yes	No	_____	Asthma	Yes	No	_____
Arthritis	Yes	No	_____	Hypoglycemia	Yes	No	_____
AIDS/HIV	Yes	No	_____	Bladder Problems	Yes	No	_____
Latex Sensitivity	Yes	No	_____	Tumors	Yes	No	_____
Hepatitis (A, B, C)	Yes	No	_____	Anxiety	Yes	No	_____
Psychiatric/Psychological	Yes	No	_____	Bleeding Disorders	Yes	No	_____
Osteoporosis/Osteopenia	Yes	No	_____	Loss of Balance	Yes	No	_____

Please list **all known allergies**: _____

Please list **ALL** prescription medications, over-the-counter medications and any supplements below – even if they are not related to your current condition. You may also attach a medication list.

Name of medication	**Dosage**	**Frequency**	**How Taken: Oral, Injection, Patch, etc**

Signature: _____ **Date:** _____

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Returning Patient Medical Registration Form (Page 3)

Please answer the following about your current condition (indicate all that apply):

Location of your symptoms: _____ **When did your symptoms begin?** _____

Work Related Injury? YES____ NO____ Date of Injury: _____ Are you currently working? YES____ NO____

Motor Vehicle Accident? YES____ NO____ Date of Accident: _____ Lawsuit/legal action pending? YES____ NO____

Sports Injury? YES____ NO____ Date: _____ Sport(s): _____ Still participating? YES____ NO____

Symptoms: Pain Stiffness Weakness Numbness Tingling Instability Other: _____

Do you have numbness? YES____ NO____ Tingling? YES____ NO____ Symptoms wake you at night? YES____ NO____

Quality: Sharp Dull Achy Burning Sore Other: _____

Severity: Mild Moderate Severe Varies Other: _____

Context: At Rest Standing Sitting Lying Down Walking Stairs Driving Dressing Hair Care

At Work Reaching Lifting Overhead Motion Gripping Computer Work Sleeping

Exercise Running Throwing Jumping Kicking Cutting Sprinting Squatting

Other positions/activities that cause your symptoms: _____

Imaging for this injury: X-Ray _____ MRI _____ CT Scan _____ Bone Scan _____ Results (if known): _____

Have you tried: Ice Heat Rest Stretching Medications (please specify): _____

Massage Chiropractic Physical Therapy Injections (type/date): _____

Have you had physical or occupational therapy this year? YES ____ NO ____ If YES, how many visits? _____

If YES, was it for your current condition? YES ____ NO ____

Past Orthopedic Problems: Low Back Pain Headaches Shoulder(s) Neck Elbow/Wrist/Hand TMJ

Hip(s) Knee(s) Ankle(s) Other: _____

Surgical History:

Procedure:	Date:	Surgeon:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Signature: _____ **Date:** _____

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Returning Patient
Medical Registration Form (Page 4)

INSURANCE COVERAGE:

A PRESCRIPTION FOR PHYSICAL THERAPY FROM A DOCTOR IS REQUIRED.

It is the patient's responsibility to contact his/her insurance company and obtain approval and coverage prior to the first visit. WE ARE NOT RESPONSIBLE FOR CALLING YOUR INSURANCE COMPANY FOR VERIFICATION.
We will make a copy of your insurance cards when you come in and all charges will be submitted by Praxis.

Here is the information that you will need when you call:

Praxis Tax ID #20-1444683
Michael Kordecki- IL License #070-00458

OUR FINANCIAL POLICY IS AS STATED:

- **All co-pays, co insurance and deductibles are due at time of service.**

- **Payment is due in full at time of service.** You are responsible for all durable goods at time of acceptance. We accept cash, checks, and credit cards.

I have read the above policies and agree to them. I authorize Praxis Physical Therapy to provide me with physical therapy services and to furnish further information to my insurance company and my physician concerning my injury and treatment. I understand that I am financially responsible for payment of all services as described above.
I know that verification is not a guarantee of payment and that I am responsible for any unpaid balances left after my insurance.

Signature: _____Date: _____

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Returning Patient
Medical Registration Form (Page 5)

Financial Policy

Thank you for choosing Praxis Physical Therapy and Human Performance as your health care provider. We are committed to the successful treatment of your condition. Please understand that payment of your bill is considered part of your treatment. Your clear understanding of our Financial Policy is important to our professional relationship. Please contact our Medical Billing Department if you have any questions.

Payment is due at the time of service. We accept cash, check, and credit cards. All patients must complete out "Medical Registration Form" and other related forms. For cases which we bill insurance directly, we must have a copy of the insurance ID card and your written prescription.

IF PAYMENT IS NOT RECEIVED FROM THE INSURANCE CARRIER, WE HAVE THE RIGHT TO BILL YOU DIRECTLY. Please notify us immediately of any changes in your insurance coverage.

Payment for all co-pays, co-insurance and deductibles are due at time of service.

Praxis is an independently owned small business. It is our goal to focus on providing you with quality physical therapy services. We do not have the resources to repeatedly track down unpaid claims, for which, you as the patient are ultimately responsible. Please read carefully the summary of our financial policy. Detailed information is provided:

1. For all our patients we will submit a claim to your insurance provider.
2. In the event, we do not receive payment within 30 days, we will contact your insurance provider once on your behalf for each date of service.
3. If your insurance provider has not responded to our submitted claim and phone calls for unpaid balances, you will be responsible for the payment.
4. All outstanding balances are due in 30 days, balances over 30 days will incur a monthly financial charge of 2.5% per month.
5. Your insurance coverage is a contract between you and your insurance company.
6. All accounts with balances over 90 days, without an established payment plan, will be sent to a collection agency, regardless of the circumstances. You, the patient/responsible party, are responsible for all collection agency fees.

Printed Name of Patient: _____ **Date:** _____

Signature of Patient or Responsible Party: _____

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Returning Patient
Medical Registration Form (Page 6)

Financial Policy (continued)

For copies of medical records: 24-hour notice is required for copies of medical records and there may be a nominal fee to cover recovery and processing expenses.

UCR (Usual and Customary Rates): We are committed to provide the best treatment possible for our patients and we charge what is usual and customary for our area. You are responsible for payment in full regardless of any insurance company's arbitrary determination of UCR rates. Claims processed by your insurance company are based on medical necessity, which is no guarantee of payment.

Self Pay: Payment is due at time of service.

Workers Compensation: If you are here as a result of work related injury, we will require information regarding both health insurance and your employer's Workers' Compensation insurance. We will also need to verify that your employer assumes responsibility for charges incurred. If we cannot verify responsibility or we are unable to obtain information on your employer's Workers' Compensation insurance, as a courtesy we will bill your insurance carrier. If payment is not received from these third parties within 60 days, you are responsible for the balance.

Accident Claims: If you are here as a result of an accident claim, we require information from both your health insurance and accident insurance companies. Our medical billing department will identify your insurance coverage. We do not hold claims until Physical Therapy treatment is completed or settlements have been made. Payment is expected at time of service. In the event we do not receive payment from the insurance company, you will be personally responsible for all charges.

I authorize Praxis Physical Therapy to bill my credit card directly for physical therapy treatment provided.

Patient Name: _____ Name on Credit Card: _____

Billing Address: _____

City: _____ State: _____ Zip Code: _____

Type of Card: VISA MASTERCARD AMERICAN EXPRESS DISCOVER

Account Number: _____ Expiration Date: _____

Signature: _____ **Date:** _____