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

Medicare Insurance 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. **All of the attached forms are REQUIRED BY MEDICARE.**

Patient Name: _____ Date: _____

Home Address: _____

City: _____ Zip: _____ Home Phone: _____

Cell Phone: _____

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

Marital Status: Single____ Married____ Separated____ Widowed____ Divorced____

Name of Spouse: _____

Occupation: _____ How Long: _____ Work Phone: _____

Employer (patient or parents): _____

Work Address: _____

How did you hear about Praxis? Physician Friend/Family Online Insurance Advertisement Other

Insurance Information:

Primary Insurance Company: _____ Policy: _____

Secondary Insurance Company: _____ Policy: _____

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

Referring Physician: _____

Address: _____ City: _____

Signature: _____ **Date:** _____

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

Medicare Insurance 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**: _____

MEDICARE REQUIREMENT: 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:** _____

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

Medicare Insurance 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:** _____

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

Medicare Insurance Registration Form (Page 4)

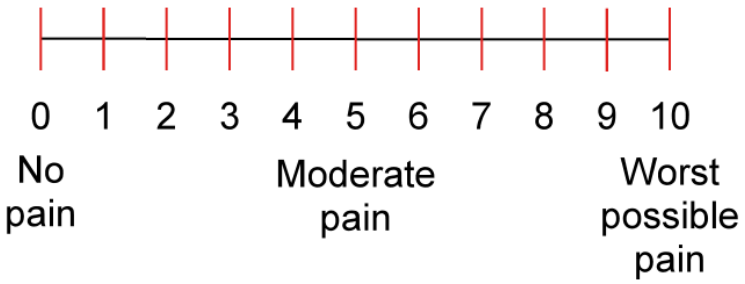
Pain Assessment — Required by Medicare

Name: _____

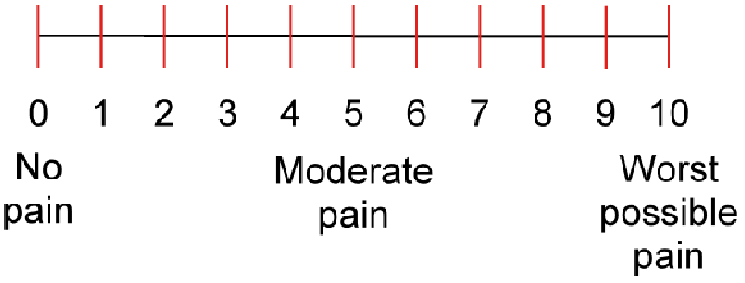
Date: _____

Instructions: Please indicate which level of pain you have been feeling from your current condition **OVER THE LAST WEEK:**

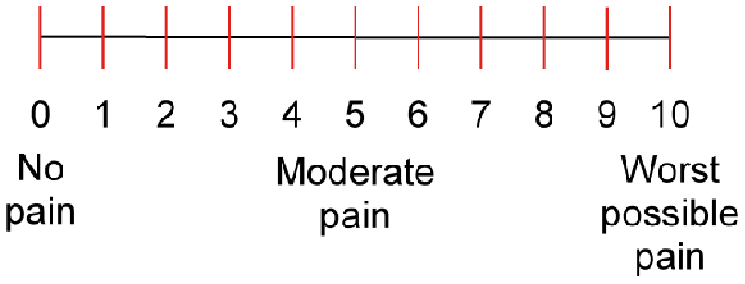
Today:



At Worst:



At Best:



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

Medicare Insurance Registration Form (Page 6)

INSURANCE COVERAGE:

A PRESCIRPTION 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

We accept Medicare assignment, but there are a limited number of visits allowed per calendar year. The Physical Therapy cap for Medicare this year is $1,900.00. You are responsible for all durable goods (i.e. braces, pulleys, and tubing) at time of acceptance. We do not bill Medicare for these items.

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:** _____