PATIENT DATA SHEET

Last Name	First Name		MI
Address	City	State	Zip Code
Home Phone	Cell Phone		
Work Phone	Email		
Date of Birth	Sex: M F U	Marital Status: S M D W	
Emergency Contact		Phone Number	

RESPONSIBLE PARTY INFORMATION

(IF PATIENT IS A MINOR)

Last Name	First Name		MI
Address	City	State	Zip Code
Home Phone	Cell Phone		
Work Phone	Email		
Social Security #	Date of Birth		Sex: M F U

IS INJURY RELATED TO: (CHECK ONE)

☐ WORK ☐ AUTO ☐ OTHER (EXPLAIN) _____

IF CLAIM IS WORK RELATED:

Employer Name			
Employer Address			
City	State	Zip Code	
Insurance Carrier		Claim #	
Adjuster		Phone #	Fax#
Billing Address			
City	State	Zip Code	

Northwest Orthopaedics & Sports Medicine
Physical Therapy Department
7447 W Talcott Ave. • Suite 501 • Chicago, IL 60631
Phone 773-631-4112 • Fax 773-594-2113

PATIENT RESPONSIBILITIES

Northwest Orthopedics and Sports Medicine will bill your insurance company. Please have all **current** insurance cards available so that we may copy the front and back of the card for accurate information. It is your responsibility to inform Northwest Orthopaedics and Sports Medicine of **any** insurance changes. If accurate insurance information is not provided for timely submission of a claim, you will be held responsible for the full amount of the charges.

Even within a particular insurance company, there are many policies available. Because of the many differences among insurance plans, we cannot advise you about your particular policy. Resources are available through your insurance company to help you understand your insurance coverage. The services will help you to verify that Northwest Orthopedics and Sports Medicine is a participating provider with your insurance company.

For insurance plans requiring co-pays, these must be paid *prior* to each visit.

I have read the above information. I understand that I am responsible for understanding my insurance coverage. 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 except financial responsibility for services not covered by my particular plan.

_____
Patients Last, First Name

_____ _____
Patients/ Signature Date

CONSENT FOR CARE AND TREATMENT

I, undersigned, do hereby agree and give my consent for Northwest Orthopaedics & Sports Medicine Physical Therapy Department to furnish medical care and treatment to _____ considered necessary and proper in treating their physical condition.

Patient/Guardian _____ Date _____

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I, hereby assign all medical benefits to include major medical benefits to which I am entitled, Including private insurance and any other health plans to Northwest Orthopedics and Sports Medicine Physical Therapy Department. A photocopy of this assignment is to be considered as valid as the original. I, hereby authorize said assignee to release all information necessary, including medical records to secure payments.

Patient/Guardian _____ Date _____

Financial policy statement

It is our policy to bill your insurance carrier as a courtesy to you, although you are responsible for the entire bill when services are rendered. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. If your insurance carrier in excess of the balance of your account subsequently makes any payment, we will promptly refund the credit.

If a payment is made directly to you for services billed by us, you recognize an obligation to promptly remit the same to Northwest Orthopedics and Sports Medicine.

The above does not apply for those patients that are considered workers compensation; however, be advised as a compensation patient that you may be held responsible for your charges in the advance your claim is disputed.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, after such default in upon referral to a collection agency or attorney by Northwest Orthopedics and Sports Medicine, I will be responsible for all costs of collecting money owed, including court costs, collection agency fees, and attorney fees.

ESTIMATED INSURANCE BENEFITS

Estimated patient payment % _____

Arrangements for payment of patient's share _____

Note: Estimated coverage information is provided as a courtesy to our patients, but is not intended to release them from total responsibility for their account balance.

The above information has been read and explained to me. I UNDERSTAND MY RESPONSIBILTY FOR PAYMENT OF MY ACCOUNT.

_____ _____

Patient /Responsible Party Signature Date

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1. Name _____ Date of Birth _____
2. Occupation _____
   Type of work (i.e. lifting, standing)_____
3. Past Medical History

Do you have any history of:

- ☐ High Blood Pressure
- ☐ Heart Condition
- ☐ Strokes
- ☐ Diabetes
- ☐ Pacemaker
- ☐ Seizures
- ☐ Cancer
- ☐ Other _____

4. Have you been admitted to the hospital or undergone any surgical procedure(s) during the last 5 years? ☐ YES ☐ NO
   If yes,
   Year _____
   What is the condition? _____
   What hospital? _____
   What was the treatment? _____
   Is this condition the reason you were referred to Physical Therapy? ☐ YES ☐ NO

5. Have you received any Physical Therapy treatments during the past 5 years? ☐ YES ☐ NO
   If yes, please specify_____
   What was the treatment? _____

6. Have you had any other previous medical problems or surgeries? ☐ YES ☐ NO
   If yes, please specify_____

7. Have you had any previous orthopaedic problems? ☐ YES ☐ NO
   If yes, name of orthopaedic doctor _____
8. Medication
   Type _____
   Reason _____

9. Exercise/Activity Level (circle one)
   0-days/week 1-2 days/week 3-5 days/week 6-7 days/week
   Type of activity? _____

10. Primary Care Doctor _____

_____ _____

Patient's Signature Date

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Please fill out the form below, listing all of your current medications, including any vitamins or supplements

Medication	Dosage	Daily Frequency	Mode of Administration (please circle one)
		________________X/DAY OTHER:	ORAL INJECTED INHALED INTRANASAL OTHER:
		________________X/DAY OTHER:	ORAL INJECTED INHALED INTRANASAL OTHER:
		________________X/DAY OTHER:	ORAL INJECTED INHALED INTRANASAL OTHER:
		________________X/DAY OTHER:	ORAL INJECTED INHALED INTRANASAL OTHER:
		________________X/DAY OTHER:	ORAL INJECTED INHALED INTRANASAL OTHER:
		________________X/DAY OTHER:	ORAL INJECTED INHALED INTRANASAL OTHER:
		________________X/DAY OTHER:	ORAL INJECTED INHALED INTRANASAL OTHER:
		________________X/DAY OTHER:	ORAL INJECTED INHALED INTRANASAL OTHER:
		________________X/DAY OTHER:	ORAL INJECTED INHALED INTRANASAL OTHER: