Balance Chicago Physical Therapy Intake Form

Name: _____ Date of Birth: _____

Height: _____ Weight: _____ Blood Pressure: _____ Referring Doctor: _____

What is your reason for seeking care? _____

When did the problem begin? _____

What tests been done for your current condition? _____

Have you seen a doctor or been hospitalized for your condition in the past year? ☐ Yes ☐ No

Have you had any surgeries? ☐ Yes ☐ No If yes, what & when? _____

Is your injury the result of a fall? ☐ Yes ☐ No Have you fallen in the last 12 months? ☐ Yes ☐ No

Did you sustain an injury from the fall? ☐ Yes ☐ No Have you fallen 2 or more times this year? ☐ Yes ☐ No

Is anyone coming into your home to help you? ☐ Yes ☐ No If yes, who? _____

Do you have pain/dizziness (circle one) now? ☐ Yes ☐ No

What makes it better? _____

What makes it worse? _____

Does your pain/dizziness interfere with your daily life? ☐ Yes ☐ No

Please rate your pain/dizziness from 0-10 (0 = no pain/dizziness. 10 = extreme pain/dizziness)

_____/10 (Currently) _____/10 (Best) _____/10 (Worst)

Do you have any of the following medical conditions?

☐ Allergies _____ ☐ Anxiety ☐ Arthritis ☐ Asthma ☐ Cancer ☐ Multiple Sclerosis

☐ Depression ☐ Diabetes ☐ Eating Disorder ☐ Fibromyalgia ☐ Hearing Problem ☐ Heart Disease

☐ High Blood Pressure ☐ High Cholesterol ☐ HIV/AIDs ☐ Insomnia ☐ Joint Injuries ☐ Migraines

☐ Osteoporosis ☐ Parkinson's ☐ Pacemaker ☐ Rheumatoid Arthritis ☐ Seizures

☐ Sleep Apnea ☐ Stroke ☐ Vision Problems ☐ Other _____

Medication List - Please Indicate Dosage:

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Appointment Policy

I, the patient, agree to be on time to receive the therapist's services for every appointment. I will make sure to see the front desk so that I can be checked in and my check in time will be recorded. I understand that reminder emails may be provided as a courtesy but I am still responsible for my appointments and any consequences associated with failing to keep or be on time to an appointment. I agree to *give at least 24 hours notice for any appointment I need to miss, cancel, or reschedule* or be subject to a **$50 missed appointment fee.**

I, _____ (name) have read and understand the above agreement and agree to comply fully with collections of any fee that I owe.

Patient's Signature: _____ Date: _____

Email Address (for email receipts): _____

Card on File Policy

Effective January 1, 2012, LifeStyle has implemented a new card on file policy. Your information will be securely held to cover future charges with your notification before any transactions are processed. Signing this consent in no way compromises your ability to dispute a charge or question your insurance company's determination of payment. I hereby authorize LifeStyle Physical Therapy and Balance Center to keep my card information on file for payment of any or all charges for medical services for which I am financially responsible and that remain unpaid after applying insurance payments and adjustments, if any. If my card information changes for any reason I will notify LifeStyle. This consent shall remain in effect for one (1) year from the date set forth below or until I give written notification of its termination. *Please complete the credit card authorization form OR hand your card to the front desk person to swipe into the system*.

Credit Card Type: ☐ Visa ☐ Master Card ☐ Discover Card ☐ AMEX

Name on Card: _____ Card Number: _____ Exp: ____/____

Billing Street Address: _____ City, State, Zip: _____

Advanced Notice of Non-Coverage (Vestibular Only)

The services listed below are considered diagnostic tests and may not be covered by your insurance plan even though your healthcare provider has clinical reasons for performing them. LifeStyle wants you to be informed that you may be responsible for the cost of the procedures if your insurance company decides to not cover these tests.

Code	Name	Actual Price	Patient's Discounted Price
95992	Canalith Repositioning Maneuver	$150	$31
92542	Positional Nystagmus Test	$200	$28
92541	Spontaneous Nystagmus Test	$200	$28
92544	Optokinetic Nystagmus Test with Recording	$100	$25
92545, 92576	Oscillating Tracking Test, with Recording & Sinusoidal Vertical Axis Rotational Testing	$120/$250	$25/$50
97750	Functional Test with Report	$75	$20

If you want the services above to help provide diagnostic care, please check yes and sign below.

☐ Yes ☐ No Patient Signature: _____ Date: _____