Physical Therapy Intake Form

Name: _____ Date of Birth: ___/____/____Height: _____ Weight:_____

Referring Doctor:_____ Primary Care Physician_____

What is your reason for seeking care? _____

How did you find Balance Chicago? _____

When did the problem begin? _____

What tests have 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**
If yes, how many falls?_____

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

Do you have pain/dizziness now? □ Yes □ No

What makes it better? _____
What makes it worse? _____

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

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

Please check all symptoms/conditions you have had:

□ Allergies	□ Anxiety	□ Asthma	□ Crohn's Disease
□ Cancer	□ Depression	□ Diabetes	□ Eating Disorder
□ Fibromyalgia	□ Hearing Problem	□ Heart Disease	□ High Blood Pressure
□ High Cholesterol	□ HIV/AIDS	□ Insomnia	□ Joint Injuries
□ Multiple Sclerosis	□ Osteoporosis	□ Parkinson's Disease	□ Pacemaker
□ Sleep Apnea	□ Seizures	□ Migraines	□ Rheumatoid Arthritis
□ Stroke	□ Vision Problems	□ Other: _____	

Medication List - Please Indicate Dosage:

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Additional Questions:

Were you involved in any car accidents? □ **Yes** □ **No** _____
Did you have any serious falls/injuries as a child? □ **Yes** □ **No** _____
Do you drink alcohol? □ **Yes** □ **No** _____
Do you smoke cigarettes? □ **Yes** □ **No** _____
Do/did you take/use recreational drugs? □ **Yes** □ **No** _____
Is this a legal/workman's comp care? □ **Yes** □ **No** _____

BALANCE CHICAGO

Financial Policy

We will verify your insurance benefits as a courtesy to you. Your insurance will provide a quote of benefits, not a guarantee of payment. Your insurance company retains the right to deny service payments and/or pay at a different percentage than quoted. Your insurance contract is between you, your employer, and your insurance company. We are not party to that contract. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date services are rendered.
_____ **(initial)**

Please note that the out-of-network benefits may apply if we are not contracted with your insurance company. _____ **(initial)**

If you have Medicare and a supplemental insurance, Medicare will send the claim to your secondary insurance on your behalf.
_____ **(initial)**

If your insurance company requires a referral or prescription, you are solely responsible for obtaining a valid referral/prescription
_____ **(initial)**

If your insurance company has not paid a claim within (90) days of submission, you accept responsibility for payment in full of any outstanding balance. _____ **(initial)**

Your copayment, coinsurance, deductible and self pay costs (including taping/needle fees) must be paid at the time of service.
_____ **(initial)**

Any balances over 30 days will be charged to your credit card on file. _____ (initial)

All services must be paid in full if you are satisfying a deductible set by your insurance company. _____ **(initial)**

If you discontinue care for any reason other than discharge by the doctor, all patient balances become immediately due and payable in full by you, and you authorize us to use your credit card to collect full payment. _____ (initial)

In the case that an account becomes delinquent (90 days past due) and we are unable to charge your credit card for the balance due, your account will be turned over to a third-party collection agency. If this occurs, our staff will no longer handle the account and all correspondence and phone calls will be directed to the third party agency. _____ **(initial)**

All patients are required to maintain a valid credit card on file with us. If you choose not to provide this information, we will not bill your insurance and you must pay cash for all services provided to you. _____ (initial)

Cancellations:
Scheduled visits are available for all services at Balance Chicago. If you are unable to make your appointment, 24-hour notice is required. If you make an appointment on another patient's behalf, you assume all financial responsibility for that appointment in the event of cancellation or missed appointment.
Any missed appointment carries a charge of $50.00.
This fee is not covered by insurance and must be paid before scheduling another appointment. _____ **(initial)**

Please note, this financial policy supersedes any and all previous financial policies, contracts, and agreements issued by Balance Chicago. _____ (initial)

Patient Name: _____ Patient Signature: _____

Printed Name (as it appears on card): _____
Credit Card #: _____ Expiration Date: _____
CVV Code (3 digit number on back of card): _____

BALANCE CHICAGO

Given by: _____ Date: _____

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. Balance 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
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: _____