Karen Ruiz Physical Therapy: Patient Medical Information

ARE YOU CURRENTLY UNDER THE CARE OF (PLEASE CHECK ALL THAT APPLY):

MEDICAL DOCTOR _____PSYCHIATRIST/PSYCHOLOGIST_____

PHYSICAL THERAPIST _____CHIROPRACTOR_____

OSTEOPATH_____DENTIST_____

OTHER_____

HAVE YOU EVER BEEN DIAGNOSED WITH ONE OF THESE CONDITIONS? If YES, please describe:

_____AIDS	_____DETACHED RETINA	_____MULTIPLE SCLEROSIS
_____ANEMIA	_____DIABETES	_____OSTEOPOROSIS
_____ASTHMA	_____EMPHYSEMA/BRONCHITIS	_____PACEMAKER
_____ARTHRITIC CONDITIONS	_____EPILEPSY	_____RHEUMATOID ARTHRITIS
_____BLADDER PROBLEMS	_____HEART PROBLEMS	_____SEIZURES
_____CANCER	_____HEPATITIS	_____STROKE
_____CIRCULATION PROBLEMS	_____HIGH BLOOD PRESSURE	_____THYROID PROBLEMS
	_____KIDNEY DISEASE	_____TUBERCULOSIS

OTHER (PLEASE DESCRIBE):_____

PLEASE LIST ANY MEDICATIONS YOU ARE TAKING:

_____

PLEASE LIST ANY MEDICATIONS TO WHICH YOU ARE ALLERGIC:

_____

ARE YOU LATEX SENSITIVE? YES_____ NO_____

ANY OTHER ALLERGIES? YES_____ NO_____ IF YES, EXPLAIN:_____

HAVE YOU HAD ANY OF THE FOLLOWING DIAGNOSTIC TESTS PERFORMED FOR THIS CONDITION? CHECK ALL THAT APPLY:

X-RAY_____ MRI_____ CT SCAN_____ DEXA SCAN_____ BONE SCAN_____

_____ _____

PATIENT SIGNATURE ***DATE***

KRPT PATIENT INFORMATION

PATIENT NAME_____

DATE OF BIRTH_____

HOME PHONE#_____ CELL PHONE#_____

WORK PHONE#_____ EMAIL_____

ADDRESS_____ CITY, ZIP_____

SINGLE_____ MARRIED_____ EMPLOYED_____ FULL TIME STUDENT_____

OCCUPATION_____

LEISURE ACTIVITIES_____

_____

EMERGENCY CONTACT NAME_____
PHONE_____RELATIONSHIP_____

REFERRING PHYSICIAN_____PHONE_____
INTERNIST_____PHONE_____
ADDRESS_____CITY,ZIP_____

PRIMARY INSURANCE
TYPE_____NAME OF INSURED_____
ID NUMBER_____GROUP#_____
RELATIONSHIP TO INSURED SPOUSE____ CHILD_____ SELF_____
INSURED EMPLOYER_____
INSURED DATE OF BIRTH (if patient is not insured)_____

SECONDARY INSURANCE
TYPE_____NAME OF INSURED_____
ID NUMBER_____ GROUP #_____

PATIENT NAME_____

CONSENT TO EVALUATION AND TREATMENT I hereby consent to the evaluation and treatment by *Karen Ruiz P.T.*. I understand it is my right to accept or refuse any treatment offered to me. I acknowledge and understand that no guarantee has been made to me as to the results that may be obtained from such treatment.

RELEASE INFORMATION I authorize *Karen Ruiz P.T.* to release from my medical record, whether it be written, video, photographic, audio or verbal, to my physician and/or any third party payer (such as insurance company or governmental agency) for its use in processing claims for payment. I understand the nature of the authorization and have been informed that I have the right to revoke consent at any time by written communications with custodians of records. I consent to the use of non-personally identifying information for the medical record purpose of outcome analysis.

HIPAA CONSENT Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting *Karen Ruiz Physical Therapy, 444 Skokie Blvd, Suite 310, Wilmette, IL 60091*.
You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or healthcare operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.
By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this consent in writing, except where we have already made disclosures in reliance on your prior consent.

AGREEMENT OF BENEFITS I request that payment of insurance benefits be made on my behalf to *Karen Ruiz Physical Therapy* for any services furnished to me by *Karen Ruiz P.T.*. I authorize the above mentioned parties to release any information required to process this claim.

FINANCIAL AGREEMENT The undersigned agrees, whether signing as agent or patient, that s/he individually obligates her/himself to pay for services rendered in accordance with the regular rates and terms of the therapists at *Karen Ruiz Physical Therapy*. The agent/patient is responsible for any co-payment, deductible, coinsurance, and all amount identified by the insurer as the patient's responsibility.

24-HOUR CANCELLATION POLICY As a full hour appointment is reserved for you, a fee of the full session rate will be charged for any no-shows or appointments cancelled within the 24-hour period. Your insurance cannot be billed for this fee. Please initial here _____

The undersigned certifies that s/he has read, understands and accepts the terms of this form.

_____ _____
Signature Date

_____ _____
Witness Date