Located in the Fitness Center
in the King-Bruwaert Community
6101 S. County Line Rd., Suite 57
Burr Ridge, IL 60527

DPT sport

T 630.230.9565
F 630.581.5462
www.dptsport.com

Dear Valued Patient,

Welcome to DPT Sport! We are excited that you have chosen us to take care of your physical therapy and wellness needs. All of our physical therapists have advanced doctoral degrees in physical therapy, in addition to specialist certifications, and multiple years of experience treating a variety of medical conditions. Research has shown that physical therapy is effective in restoring movement, relieving pain, strengthening muscles, improving balance, as well as enhancing overall function and preventing further injury. Our team here at DPT Sport is dedicated to providing you with exceptional care from your initial call in to our clinic to schedule your Initial Evaluation until your last visit, "Graduation Day". Our friendly staff is here to help you understand your insurance benefits and answer any additional questions that you may have about your treatment and/or associated billing.

Your Initial Evaluation with us will be 40-80 minutes long and will consist of a comprehensive evaluation and assessment, education regarding your diagnosis and customized treatment plan as well as the start of your treatment. We will make every effort to address all of your questions and concerns.

To help us provide the best care possible, we will need the following prior to your Evaluation:

1) Completed New Patient Registration forms
2) Physician referral (if you have one...not necessary however)
3) Your insurance card(s)
4) Drivers license (or government-issued picture ID)
5) Any Lab/test results (i.e., x-ray, MRI, CT reports) relevant to your current condition

Please wear or bring comfortable clothing and tennis shoes that will allow therapist to evaluate the involved region (i.e., shorts for knee or hip injuries, tank top for neck or shoulder injuries, etc.) and allow you to move freely to perform various activities and/or exercises. A washroom is available for clothing changes, however please secure all personal items; DPT Sport is not responsible for any lost or stolen items.

Our clinic is located in the fitness center of the King-Bruwaert Community in Burr Ridge, Illinois. Our address is 6101 S. County Line Rd, in Suite 57. Please call us at (630) 230-9565 with any questions.

Thank you again for choosing DPT Sport and entrusting us with your care. We look forward to meeting you and earning your trust as your "go to" primary musculoskeletal medical provider!

Warmest Regards,

Christine Klody
Founder and President-DPT Sport
Doctor of Physical Therapy

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PATIENT INFORMATION

Patient Name: Last_____ First_____ MI ___ Today's Date: _____
Male ☐ Female ☐

Prefers to be called_____ Date of Birth_____ Age ___ Marital Status: S ☐ M ☐ D ☐ W ☐

Address_____ Apt #_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____

Where do you prefer to receive calls? Home ☐ Cell ☐ Work ☐ Email _____

How do you prefer to receive appointment reminders? ☐ Text Message (*standard rates apply)* ☐ Email

How did you hear about DPT Sport?_____

Occupation_____ Employer Name_____

Employer Address_____ Employer Phone_____ Full-time ☐ Part-time ☐ Other ☐

Emergency Contact: Name_____ Relationship_____ Phone_____

Referring Physician Name (if have referral)_____ Phone_____

Date of next appointment with physician_____

Primary Care Physician Name (first and last name)_____ **OR** ***(check)*** ☐ No Physician

May we contact your physician? Yes ☐ No ☐ Phone_____

Injured Body Part_____ R ☐ L ☐ N/A ☐ Date of Injury/Symptom Onset_____

Have you had any Physical or Speech Therapy within the current calendar year?_____

Auto Accident? ☐ Yes ☐ No If Auto, what state? _____ Another Type of Accident? ☐ Yes ☐ No

Work-related? ☐ Yes ☐ No Attorney Involved? ☐ Yes ☐ No Case Manager_____

Consent to Treat, Authorization and Release:

I hereby authorize and consent to medical examination and treatment as deemed necessary and appropriate for my condition or illness in the judgement of my physical therapist, to be performed by my physical therapist. I certify that the information provided by me for purposes of payment for this treatment is, to the best of my knowledge, complete and accurate. I authorize the release of any information to third party payors, government agencies, and/or entities involved in billing and collection in order to process my claims. I authorize and request my insurance company to pay all assigned insurance benefits directly to DPT Sport, PC on my behalf. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

*Signature*_____ *Date:*_____

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MEDICAL HISTORY

Height_____ Weight _____ Are you: ☐Right-handed ☐ ☐Left-handed

Brief description of current symptoms: _____

_____

Currently working? ☐ ☐Y ☐N Occupation: _____ Work-related Injury? ☐Y ☐N

Leisure activities, including exercise routine: _____

Do you use an assistive device for mobility? ☐ ☐Y ☐N With whom do you live? _____

Rate your general health: ☐ ☐Excellent ☐ ☐Good ☐ ☐Fair ☐ ☐Poor

f Drink alcohol? ☐Y ☐N How often? _____ History of chemical dependency? ☐Y ☐N

Check all of those that apply to your current condition:

☐Aggravation of pre-existing/recurring injury ☐Motor vehicle accident ☐Fall
☐Sports injury ☐Causes unknown ☐Lifting injury ☐Other_____

Date of injury/Symptom onset: _____ Have you ever had these symptoms before? ☐Y ☐N

Have you received treatment for these symptoms? ☐ ☐Y ☐N If yes, what type: _____

Have you had physical or speech therapy (outpatient clinic or home health) within the last calendar year? ☐Y ☐N

What type of testing had been done on this body part(s): (check all that apply)
☐X- Ray ☐MRI ☐CT Scan ☐Other Results: _____

What have you been doing to decrease your symptoms?_____

_____

Symptoms getting: ☐Worse ☐Same ☐Better Causing difficulty sleeping? ☐Y ☐N

On a scale of 0 (no pain) to 10 (emergency room), what is your pain level:

Currently? _____ At worst in past two weeks? _____ On average in past two weeks? _____

Aggravating factors (Positions and/or activities that make your symptoms worse):
1._____ 2._____ 3._____

Easing factors (Positions and/or activities that make your symptoms better):
1._____ 2._____ 3._____

Check any of the following activities that you have difficulty with due to your symptoms:

☐ Lifting ☐Dressing ☐Reaching ☐Housekeeping ☐Cooking ☐Negotiating stairs
☐Child care ☐Bending ☐Sit to stand ☐Yard work ☐Driving ☐Shopping ☐Exercising

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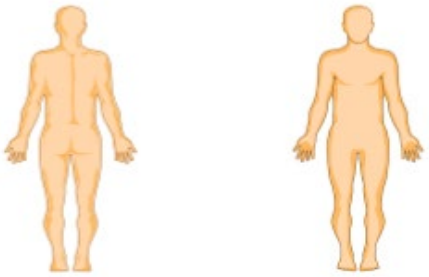
Body Chart:

Please use the diagram to the right to indicate where your symptoms are located. Using the key below, indicate the type of symptoms experienced:

xxxxxxx Shooting/Sharp pain
oooooo Dull/Aching pain
////////// Numbness
******** Tingling



Do you currently have or do you have a history of any of the following:

	Yes	No		Yes	No		Yes	No
Allergies			**Dizzy spells**			**MRSA**		
Anemia			**Emphysema/Bronchitis**			**Multiple sclerosis**		
Anxiety			**Fibromyalgia**			**Osteoporosis**		
Arthritis			**Fractures**			**Parkinson's disease**		
Asthma			**Gallbladder Issues**			**Rheumatoid arthritis**		
Autoimmune disorder			**Headaches**			**Seizures**		
Cancer			**Hearing impairment**			**Smoking**		
Cardiac conditions			**Hepatitis (A,B, or C)**			**Speech problems**		
Cardiac pacemaker			**High cholesterol**			**Strokes**		
Chemical dependency			**High/Low blood pressure**			**Thyroid disease**		
Circulation problems			**HIV/AIDS**			**Tuberculosis**		
Currently pregnant			**Incontinence**			**Vision problems**		
Depression			**Kidney problems**			**Respiratory problems**		
Diabetes			**Metal implants**			**Bone/Joint infections**		
Nausea/Vomiting			**Blood disorder**			**Head injury/TBI**		
Hypoglycemia			**Ear ringing**			**Psychological care**		
Ulcers/GI Issues			**Dementia**			**Muscular disease**		

If "Yes" to any of the above, please explain & give approximate dates. Also, describe any other conditions not listed above: _____
_____
_____
_____

Fall History

Have you sustained an injury as a result of a fall in the past year? ☐Yes ☐ No
Two or more falls in the last year? ☐Yes ☐ No
Do you feel unsteady or at risk for falls? ☐Yes ☐ No

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Surgical History

Body Region:_____Surgery Type:_____Date: ____/____/____

Body Region:_____Surgery Type:_____Date: ____/____/____

Body Region:_____Surgery Type:_____Date: ____/____/____

Body Region:_____Surgery Type:_____Date: ____/____/____

Body Region:_____Surgery Type:_____Date: ____/____/____

Current Medications:

☐ Currently not taking any medications

Drug:_____Dosage:_____Frequency:_____Route:_____Reason Taking:_____

Drug:_____Dosage:_____Frequency:_____Route:_____Reason Taking:_____

Drug:_____Dosage:_____Frequency:_____Route:_____Reason Taking:_____

Drug:_____Dosage:_____Frequency:_____Route:_____Reason Taking:_____

Drug:_____Dosage:_____Frequency:_____Route:_____Reason Taking:_____

Drug:_____Dosage:_____Frequency:_____Route:_____Reason Taking:_____

***If more space is needed to include all of your medications, please attach a list of additional medications*

Please list any serious and/or recent hospitalizations: _____
_____

Have you RECENTLY experienced any of the following (check all that apply)?

☐ Numbness or Tingling	☐ Weight loss/Gain
☐ Constipation	☐ Heartburn/Indigestion
☐ Fever/Chills/Sweats	☐ Fainting
☐ Muscle weakness	☐ Difficulty swallowing
☐ Diarrhea	☐ Difficulty with balance
☐ Nausea/Vomiting	☐ Shortness of breath
☐ Falls	☐ Dizziness/Lightheadedness
☐ Headaches	☐ Changes in bowel and/or bladder function
☐ Cough	☐ Fatigue

Is there any other pertinent information about your present health that we should know about?

_____

_____

_____

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ATTENDANCE POLICY

In order to achieve successful outcomes in physical therapy here at DPT Sport, the three following prerequisites are necessary: (1) Regular attendance in therapy, (2) Open communication with your therapist, and (3) Consistent follow-through with your integral home exercise program.

Out of respect for your therapist, his/her valuable time as well as other patients' desires for similar appointment times with your therapist and those patients on our waitlist, **24-hour business day notice via phone call** is required to cancel or reschedule any scheduled appointment. Failure to provide 24-hour business day notice (business day ending at 5 pm) will result in a **$ 75.00 late cancellation or no show fee** (this fee must be paid prior to continuing physical therapy/your next visit; this fee is not covered by your insurance).

Patients or clients who miss **three** consecutive appointments or have **two** no show/no calls or **two** late cancellations (or generally erratic/inconsistent attendance) without a medical reason will be moved to a same day only scheduling model. All missed visits are documented in the patient's medical record; this information is shared with the referring physician (and insurer if work comp (WC) patient; this could jeopardize your claim and/or prolong/terminate any benefits that you may be entitled to. Please note- all missed WC visits must be rescheduled in the same week to prevent issues with your claim/case).

Patients must be on time for their scheduled appointment. Patients arriving more than 10 minutes late may be asked to reschedule their appointment or may have to wait until his/her next scheduled appointment.

Patients are welcome to bring a family member with them to the Initial Evaluation. However, to protect other patients' privacy, please do not bring children, spouses, or other family members into the common treatment area.

☐ *I have read DPT Sport's Attendance Policy as stated above and understand that my good communication and active participation will directly impact the success of my therapy program.*

In signing below, I agree to the terms and conditions set forth by DPT Sport in this document for treatment/services as well as payment.

_____ _____
Signature of Patient (or Legal Guardian/POA if applicable) Date

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FINANCIAL POLICY

Thank you for choosing DPT Sport as your physical therapy provider. Please take the time to read through this document, as your clear understanding of our financial policy is important to our professional relationship and ultimately, your care here at DPT Sport.

Please understand that timely payment for your physical therapy treatment is important. Insurance is a contract between you and your insurance carrier. We strongly encourage you to contact your insurance carrier to determine what coverage they provide for physical therapy. As a courtesy to you, we will verify your physical therapy benefits and also submit all claims for services rendered to your insurance provider(s), but we cannot guarantee what your insurance carrier(s) will pay. In order for our office to do this, you must provide us with all of the necessary and accurate personal and insurance information. Additionally, it is important for you to notify us immediately if any changes in your insurance or coverage are made.

DPT Sport is an in-network provider for Medicare and Blue Cross Blue Shield. (Note: If your primary insurance carrier is not one of these, you will be responsible for out-of-network rates). You will be responsible for the remaining balance that your primary insurance carrier (and secondary insurance carrier if applicable) does not pay. In addition, please be aware that some, or perhaps all, of the services provided may be considered not medically necessary by your insurance provider; you will be responsible for these charges. Most medical equipment and supplies are not considered a covered entity in your insurance plan.

Please note the following:

All co-pays and deductibles are due at the time of service in order to abide by your insurance contract. Payment of your current patient balance (already processed through your insurance carrier) is due in full in office at the time of your next visit. Monthly statements will be sent out from our billing department, billing any charges not processed by the time of service. After being discharged, payment for any unpaid statement balances is due within 30 days of the statement date. If any portion of your account balance exceeds 60 days, your account will be submitted to a collections agency and you will be responsible for this amount plus interest herein at 2% per month in addition to any collection agency fees.

DPT Sport, PC accepts payment by cash, check, and the following credit cards: Visa, MasterCard, American Express, and Discover. The card must be physically present to charge. We will not take credit card numbers over the phone for your security and protection. Alternatively, patients may request electronic invoices to be emailed to them, where they can then follow the secure link to pay online via the company's Square credit card processing system. Please advise our Front Desk Coordinator if you would like to do so.

Thank you for understanding our financial policies. If you have any questions or concerns, please do not hesitate to contact Christine Klody (President of DPT Sport/Doctor of Physical Therapy) at (630)230-9565.

I understand that I am ultimately financially responsible for payment of all services (all outstanding balances) that are not paid by my insurance carrier(s). Should my account be referred for collection, I will be responsible to pay for the costs of collection, including legal fees.

Patient Name (Please Print)_____

(*If applicable)* Legal Guardian/POA Name (Please Print)_____

Signature of Responsible Party_____ **Date:**_____

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Acknowledgement of Receipt of Privacy Notice

Purpose of this Acknowledgement

This Acknowledgement, which allows the Practice to use and/or disclosure personally identifiable health information for treatment, payment or healthcare operations, is made pursuant to the requirements of 45 CFR §164.520(c)(2)(ii), part of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").

Please read the following information carefully:

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by DPT Sport, PC (the "Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the Privacy Regulations.

2. I am aware that the Practice maintains a Privacy Notice that sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice will make such use or disclosure. By signing this Acknowledgement, I understand and acknowledge that I have the right to request a copy of the Privacy Notice, upon which time the Practice will immediately provide this to me. This Privacy Notice is also located on the Practice's website online for review under the 'For Patients' section.

3. I understand and acknowledge that in its Privacy Notice, the Practice has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request for a revised Privacy Notice to the office of the Practice at the following address: DPT Sport, PC, 6101 S. County Line Rd, Suite 57, Burr Ridge, IL 60527, Attention: Compliance Officer.

4. I understand and acknowledge that I have the right to request that the Practice restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I understand and acknowledge that the Practice is not required to agree to restrictions requested by me except in very limited circumstances as described in the Privacy Notice, but if the Practice agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing. I request the following restrictions be placed on the Practice's use and/or disclosure of my health information (leave blank if no restrictions): _____

I understand the foregoing provisions, and I wish to sign this Acknowledgement authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and healthcare operations.

DPT Sport, PC and its employees may leave voicemails regarding my physical therapy care at any of the phone numbers that I have provided to them on my new patient registration forms.

I authorize that DPT Sport, PC and its employees have my permission to discuss my personal health care information relevant to my care here at DPT Sport with the below named individual(s) (full name and phone number) who play a role in my daily life including, but not limited to, my family, friends, or/or caregiver(s):_____
_____

By signing this form, I acknowledge that I have reviewed an executed copy of this acknowledgement and a copy of the Practice's Policy Notice and agree to the Practice's use and disclosure of my protected health information for treatment, payment and health care operations.

_____ ( ) _____
Printed Name of Patient (or POA/Representative if applicable) Patient's Date of Birth

_____ _____
Signature of Patient (or POA/Representative if applicable) Date

_____
Relationship to Patient

Dear Valued Patient or MVP Client,

Our practice is always looking to improve our efficiency and customer service while providing the best patient and MVP client care. We utilize a "Credit Card on File" (CCOF) system that allows for a faster, simpler payment method without the hassle.

Setting up for CCOF is easy … At your first scheduled visit, our administrative team will simply swipe your preferred credit card or HSA card. We will then save that card on file so that it can be processed seamlessly for all future visits/balances. You may save up to three cards on file. Your credit card information will be saved in the secure, encrypted Square Credit Card Processing System. No financial information will be available to our team or held in our EMR system.

Per our contractual agreements with insurers, co-pays and deductibles are due at the time of service. As the exact cost of each visit (that goes towards your deductible) is not known until that visit processes through insurance, DPT Sport collects an estimated amount per visit until you have met your plan's deductible; this estimate is $100 per visit for in-network insurers and $150 per visit for out-of-network insurers. This is only an estimate; the actual amount may be slightly more or less than this amount and will be collected once your visit has been fully processed by your insurer and our practice has received the EOB for your visit. We will charge the amount due to your card on file and will provide you with a receipt. If there is any overpayment, it will be credited to your account and if a refund is due at the end of your care with us, one will be provided promptly.

Please note: Statements with outstanding patient balances will be mailed out by our billing department on the 15th of the month. Credit cards will be processed on the 25th of the month.

Should you have any questions or concerns, please ask to speak with our Director, Christine Klody.

I have read this form and my signature below gives my authorization for DPT Sport to retain my credit card information in the Square system and for it to be processed for any patient responsibilities as it pertains to my treatment at this clinic.

Patient Name (printed):_____ **Date:**_____

Patient Signature:_____

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UNDERSTANDING YOUR MEDICARE COVERAGE

To: Our Medicare (Part B) Patients

Congress eliminated the limits on how much Medicare (CMS) pays for (Part B) outpatient therapy services in one calendar year (formerly known as the "Medicare Therapy Cap") back in 2018. However, for CMS to pay for your services, the law requires your physical therapist to confirm that your therapy services are medically necessary throughout the duration of your care, both in your medical record and on your insurance claims to CMS.

It is your physical therapist who decides whether skilled physical therapy is medically necessary (not Medicare and not your physician). *If your therapist deems that skilled physical therapy is still medically necessary* ***by Medicare standards***, he/she will document this in your medical record and on your claims, thus communicating this need to CMS, and continue on with your treatment/plan of care. As a Medicare requirement, we do need to know and it is your responsibility to let our team know how many Medicare Part B (outpatient) therapy dollars (physical and/or speech therapy) have been used in the current year so that we may include this in our documentation. CMS tracks, but does not cap, the dollars that you use in therapy. As long as we have been given accurate information regarding any therapy dollars that may have been used earlier in the year, CMS should be able to process and pay your claims expediently without issues.

At the time when your therapist feels skilled physical therapy is ***no*** *longer medically necessary*, he/she will give you two options to choose from:

(1) You may elect to be discharged with an independent home exercise program (HEP).
(2) You may elect to continue with physical therapy, but will then be changed over to a self-pay patient (responsible for full balance/charges at DPT Sport's self-pay rates); in this case, you will need to sign a CMS form accepting responsibility for paying out of pocket for therapy services that are not deemed medically necessary per CMS standards.

Please note: Your Medicare deductible **($ 233 for 2022)** is due at the time of service. After you have met your Medicare deductible (for Traditional Medicare Part B plans), CMS will pay 80% of your outpatient physical therapy charges. If you have a secondary insurance, please check with that specific plan to determine what percentage of the remaining balance that this secondary payor will pay.

There are also numerous Medicare Advantage primary insurance plans (that you may have purchased to replace your Traditional Medicare Part B plan), all with vastly different coverage benefits. We will verify these for you as a professional courtesy. These plans do follow CMS guidelines for medical necessity as described above. All deductibles and co-pays for these plans are due at the time of service.

Co-insurance amounts are due upon our practice receiving your Explanation of Benefits (EOB) from your insurance payor (which you should also receive from your insurance payor), signifying that your insurance payor has fully processed your claim(s).

Although we are here to assist you as best we can, it is ultimately a patient's responsibility to know your insurance coverage benefits as well as what benefits are still remaining. We have provided this summary of the Medicare coverage for informational purposes. Although many providers do not provide this information, we wanted to take the time to ensure that you understand your Medicare coverage. Please feel free to call our office with any questions at (630) 230-9565.