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

Instructions for Patient Portal

Welcome to DPT Sport!

There is a link in this email to our Patient Portal, which is a secure and easy way to fill out your information and upload the necessary documents to be sent directly to our DPT Sport Administrative Team. Below are the quick and easy steps to set up the portal and submit your paperwork.

Step 1 Complete pages 2-4 (2-6 if you are a pelvic health patient). Then scan forms into your computer where they can be easily found again. Please also include a front and back copy of your insurance card(s) as well as a front side copy of your photo ID. If you have a physician referral and/or test results (i.e., x-ray or MRI report), please include these as well.
Note: If you do not have a scanner to upload documents, you may take a clear and full document view photo as long as no background is visible

Step 2 Click on the Activation link in this email and set up password as directed
Your username is your email address

Step 3 "Accept" the Terms of Service

Step 4 Fill in all question fields (whether required to move forward or not)
Press "Save and Continue" on each screen

Step 5 When you get to the "Documents" tab, click "Browse" to locate and attach your completed paperwork and documents from Step 1
Each document will need a "Type", choose "Other" if you are unsure

Step 6 Electronically sign and date all 'Mandatory Documents' in the Documents section

Step 7 Once you see the green 'Signed' box (under Signing Status), click on 'Sign Out' in the left-hand menu

Please note: we do not use OptimumMe (one of the tabs in the Portal) as we have an enhanced custom home exercise portal on our website

*****Please be sure to submit all paperwork at least ONE BUSINESS DAY PRIOR to *** your Initial Evaluation so that our team has time to review/register you so that your full appointment time can be *solely dedicated to your care***

Should you have any concerns or questions, please call us at (630) 230-9565 at the clinic. We look forward to meeting you and helping you reach your goals!

Warmest Regards, *The DPT Sport Team*

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

PATIENT INFORMATION

Patient Name: Last_____ First_____ MI ____ Today's Date: _____

Male □ Female □ Age _____ How did you hear about DPT Sport?_____

Where do you prefer to receive calls? Home □ Cell □ Work □

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

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_____

If Work-related injury: 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:*_____

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

MEDICAL HISTORY FORM

Patient Name_____ Date_____

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

Brief description of current symptoms:_____

_____

Currently working? ☐Yes ☐No 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

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:_____

What type of testing has been done on this body part(s): (circle 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:

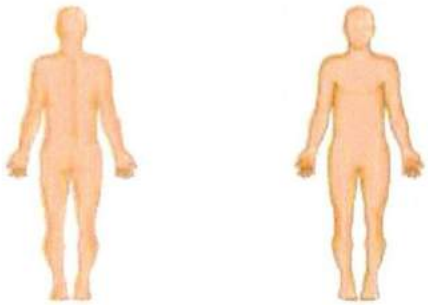
☐ Lifting ☐Dressing ☐Reaching ☐Housekeeping ☐Cooking ☐Negotiating stairs
☐Child care ☐Bending ☐Sit to stand ☐Yard work ☐Driving ☐Shopping ☐Exercising

(Please turn over for page 2)

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



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?

_____

_____

_____

DPT sport

PELVIC HEALTH HISTORY

Patient Name_____ Evaluation Date _____

Describe the main problem(s) that brought you in today:

_____

When did your symptoms begin? ____ (circle) months/years ago

Surgical History:

Surgery for your back/spine	Y N	Surgery for your bladder or prostate	Y N
Hysterectomy or other pelvic surgery	Y N	Abdominal Surgery	Y N

If answered "Y" to any of the above, please provide greater detail (i.e. procedure date, etc):

_____

Have you **EVER** experienced any of the following?

Frequent urinary tract infections	Y N	Constipation	Y N
Pelvic pain	Y N	Recurrent diarrhea	Y N
Blood in urine	Y N	Pain during or after sexual activity	Y N
Urethral stricture	Y N	Pain with pelvic or prostate exam	Y N
Endometriosis (females)	Y N	Pelvic cancer	Y N
Sexually Transmitted Infections/Disease	Y N	Sexual abuse or trauma	Y N

If answered "Y" to any of the above or have any other conditions not listed, please provide greater detail and approximate date(s):

_____

BLADDER SYMPTOMS:

Do you experience the following related to your CURRENT bladder function:

Urinary leakage with coughing, sneezing, lifting, laughing, or exercise? Y N
Urinary leakage while sleeping? Y N
Urinary leakage associated with urgency, causing you to rush to the bathroom? Y N
Urinary leakage at rest, or unassociated with any activity? Y N
Overwhelming urge to urinate or need to urinate excessively? Y N
Strain to pass urine, or have difficulty initiating a stream? Y N
Dribble urine post-urination? Y N
Go to the bathroom "just in case" when you are near a bathroom? Y N
Hover or squat over the toilet to urinate? Y N
Pain with urination? Y N
Wear protective pads for incontinence? Y N

If yes, how many pads per day? _____ What size pad: _____

How many glasses of fluid do you drink daily? _____ How many are caffeinated?_____

How many times do you urinate during awake hours? ___ During sleep hours?_____

How frequently are you experiencing leakage? _____ times per day/week (circle)

✔ ✔

(OVER)

BOWEL SYMPTOMS:

Do you experience the following related to your CURRENT bowel function:

Regular constipation?	Y N
Feeling of incomplete emptying?	Y N
Often strain or hold your breath during bowel movements?	Y N
Ever have to use your fingers to help evacuate a bowel movement?	Y N
Pain during or after bowel movements?	Y N
Bleeding when having a bowel movement?	Y N
Frequent diarrhea?	Y N
Pass gas without meaning to?	Y N
Leakage of stool (fecal incontinence)?	Y N

How often do you have a bowel movement? _____times per day/week (circle)
Is your stool typically hard or soft? _____

FOR FEMALES ONLY *(skip to the next section if male):*

Obstetric/Gynecologic History:

Are you sexually active? Y N Are you pregnant or attempting pregnancy? Y N
Are you postmenopausal? Y N *If yes, for approximately how many years?* _____
Number of pregnancies: _____
Number of vaginal deliveries and dates: _____
Number of cesarean deliveries and dates: _____
Please circle any of the following you have experienced related to childbirth:

Episiotomy Forceps/Vacuum Delivery Vaginal Tearing Prolonged Labor

Have you EVER or do you CURRENTLY experience have any of the following?

Prolapse, or feeling of something falling from the vagina	Y N	Pain with pelvic exam, tampon, or finger insertion	Y N
Painful periods	Y N	Vaginal dryness	Y N
Pain during or after sexual activity	Y N	Frequent vaginal infections	Y N

Other significant history (please describe):

_____

FOR MALES ONLY *(skip if female):*
Are you currently sexually active? Y N

Have you EVER or do you CURRENTLY experience have any of the following?

Pain in the penis, testicles, scrotum, groin, or perineum	Y N	Symptoms related to enlarged prostate	Y N
Erectile Dysfunction	Y N	Painful erection or ejaculation	Y N

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

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 any of the services provided (and considered medically necessary by your therapist) may not be considered medically necessary by your insurance provider; we cannot control how insurance payors process claims despite our strong documentation necessitating therapy services. 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, 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 reach out to our office 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 an additional 33% of my outstanding balance to cover the costs of collection. Any court costs or attorney fees if incurred would be in addition to this amount.

Signature of Patient (or Legal Guardian/POA) _____ Date_____

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

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

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

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

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

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 **($ 203 for 2021)** 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) you're 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.

_____(_____) _____

Patient Name (**and** Signature or POA signature if applicable) Date