CORE
fitness + physical therapy

2940 West 95th Street
Evergreen Park, IL 60805
708.422.0990
Fax 708.422.7130
www.corefitnesspt.com

Health History Information

Name_____ Date of Birth_____

Email_____ Next Physician Visit_____

Physician Name_____ Physician Phone _____

Emergency Contact Name_____ Emergency Contact Phone_____

How did you hear about CORE?

❑ Doctor_____ ❑ Website / Social Media ❑ Newspaper

❑ Friend_____ ❑ Other_____

Please list ALL allergies_____

_____

Please list ALL medications_____

_____

Please check ALL of the following conditions you now have or have had in the past.

❑ Alzheimers	❑ Epilepsy / Seizures	❑ Parkinson's disease
❑ Amputation	❑ GI Problems (reflux, IBS)	❑ Peripheral Neuropathy
❑ Arthritis OA/RA	❑ Head injury / Concussion	❑ Peripheral vascular disease
❑ Asthma	❑ Headaches / Migraines	❑ Psychiatric history
❑ Blood pressure (high/low)	❑ Heart conditions	❑ Raynaud's
❑ Cancer	❑ History of bone or joint fractures	❑ Recent hospital admission
❑ Circulation problems	❑ Incontinence Bowel or Bladder	❑ Skin disease
❑ CHF	❑ Infections disease (HIV, TB, etc)	❑ Sleep disorder (sleep apnea etc)
❑ COPD / Breathing problems	❑ Kidney disease	❑ Smoking / Tobacco use
❑ Current fracture	❑ Liver problems / Hepatitis	❑ Stroke / TIA / CVA
❑ Current pregnancy	❑ Lymphedema	❑ Surgery_____
❑ Depression / Anxiety	❑ Metal implants	❑ Thyroid disease
❑ Diabetes Type I or II	❑ Multiple Sclerosis	❑ Visual impairments
❑ Dizziness / Vertigo	❑ Neck or back pain	❑ Wound
❑ Durg / Alcohol addiction	❑ Osteoporosis / Osteopenia	❑ Other_____
❑ DVT (blood clot)	❑ Pacemaker / Defibillator	
❑ Fibromyalgia	❑ Paralysis	

Current Condition

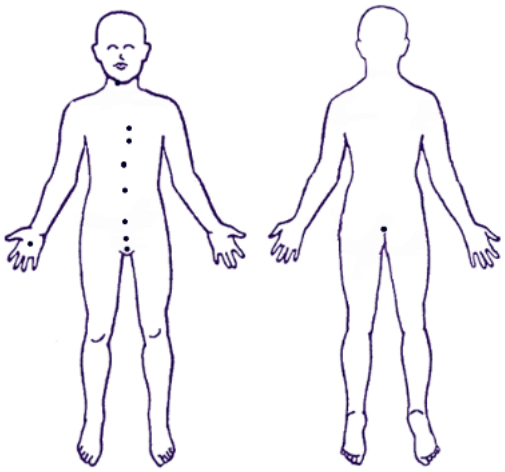
Date problem began_____

What is the primary problem, complaint or injury that brought you to therapy at this time?

_____

_____

Please shade the diagram where pain or symptoms are located:



Activities that **INCREASE** your pain or symptoms:
Activities that **DECREASE** your pain or symptoms:

If pain is part of your problem, please indicate your pain level:

No pain _____worst pain imaginable

0 1 2 3 4 5 6 7 8 9 10

Have you had: ❑ MRI ❑ X-ray ❑ CT Results_____

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Agreement for Services

Payment Terms

We strongly believe that part of a healthy working alliance involves staying current with your account at CORE Fitness and Physical Therapy. This enables us to pay your Physical Therapist for services rendered.

We are in-network with Blue Cross/Blue Shield only. If you are insured by BCBS, when you initiate services, our Billing Office will obtain a quote of benefits from Blue Cross/Blue Shield and will present this paperwork at your first visit (as a reminder, this is a quote of benefits, not a guarantee of payment). BCBS requires you to provide your insurance card and photo ID to avoid insurance fraud. If you are insured through any other carrier other than BCBS, we require a payment of $150 per visit. Most PPO plans will reimburse a portion of the cost for services received by an out-of-network provider. Our office can provide you with a self payment claim form with services rendered to submit to your insurance company. We also accept workers compensation and any patients who are involved in litigation due to an injury.

If your account has an outstanding balance, your portion of the services rendered are due at the time of service. We accept cash, check and credit card. We cannot accept Manna for insurance payments. Future appointments will be scheduled as long as your account is current.

Please see the following Credit Card Payment Authorization Form

Missed Appointment or Late Cancellation Fee

Missed appointments cannot be billed to your insurance. You will be charged $50 for appointments missed or cancelled without 24-hour notice. These charges must be paid at the next appointment or all future appointments will be cancelled.

There will be a $25 for returned checks.

If you have any additional questions or concerns, please contact our office manager at 708-422-0990.

Patient Signature_____ Date_____

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Release and Indemnification Agreement

I have requested the services of Core Fitness & Physical Therapy in connection with a program of physical exercise, which may include Pilates exercise, physical therapy, aerobic exercise and/or weight and resistance training (the "Program").

I am aware that the Program may involve certain risks of injury, and that I, rather than Core Fitness & Physical Therapy, control the nature and content of the Program. I have been examined by a physician prior to commencing the Program. In consideration of Core Fitness & Physical Therapy's services in connection with the Program, I assume the risk of any and all accidents, illnesses and injuries of any kind, which may be sustained by me by reason or in connection with my Program.

In addition, I agree that, to the fullest extent allowed by law, neither Core Fitness & Physical Therapy nor any of its owners, agents employees, personal representatives, successors or assigns shall be liable or responsible for or on account of any such accident, illness or injury, and I release, discharge, and absolve Core Fitness & Physical Therapy and its owners, agents, employees, personal representatives, successors or assigns from any and all losses, liabilities, damages, costs and obligations (or actions or claims in respect thereof) (including reasonable counsel fees), which they may suffer or incur, as such loses, liabilities, damages, costs or obligations (or actions or claims in respect thereof) arise out of or are based upon or are in any way connected with my Program.

This Agreement shall be binding upon my heirs, legatees, personal representatives, successors and assigns.

MY SIGNATURE BELOW INDICATES THAT I HAVE READ AND UNDERSTAND THIS AGREEMENT AND AGREE TO BE BOUND BY IT.

Print Name_____

Signature_____

Date_____

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Privacy Statement

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical and dental records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse Protected Health Information (PHI).

This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information
Your Protected Health Information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the practice, and any other use required by law.

Treatment: We will use and disclose your Protected Health Information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the health care professional has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, and conducting or arranging for other business activities. We may use or disclose, as needed, your protected health information to support the business activities of this practice. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may call your home and leave a message (either on an answering machine or with the person answering the phone) to remind you of an upcoming appointment, the need to schedule a new appointment or to call our office. We may also mail a postcard reminder to your home address. If you would prefer that we call or contact you at another telephone number or location, please let us know.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of HIPAA.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

The Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in you care or for notification purposes described in this Notice of Privacy Practices. Your request must state the specific restriction and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this Notice from us, upon request, even if you have agreed to accept this Notice alternatively (i.e. electronically).

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this Notice and will inform you of any changes. You then have the right to object or withdraw as provided in this Notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy officer of your complaint at our office and main telephone number. We will not retaliate against you for filing a complaint.

This Notice was published and becomes effective on/or before **1/5/2022**.

The name and address of the person you can contact for further information concerning our privacy practices are:

Privacy Officer
Core Fitness & Physical Therapy
2940 W. 95th Street
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Notice of Privacy Practices Receipt

Uses and Disclosures

I acknowledge that I have received and reviewed a copy of the Core Fitness & Physical Therapy STATEMENT OF PRIVACY that became effective January 22, 2012 which describes how health information about me or my child may be obtained, used and disclosed and how I can get access to this information.

By signing this form, I consent to Core Fitness & Physical Therapy use and disclosure of protected health information about me/my child for treatment, payment, operations and reporting as described in the Notice of Privacy Practices. I have the right to revoke this consent, in writing, except where disclosures authorized by prior consent have already been made.

Name of Patient_____

Signature of Patient_____

Signature of Guardian (if patient is under 18 years of age)_____

Date _____

OFFICE USE ONLY

I attempted to obtain the client's, parent's or guardian's signature in acknowledgment of the STATEMENT OF PRIVACY, but was unable to do so as documented below:

Date_____ Initials_____

Reason_____

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Release of Information

I hereby authorize Core Fitness and Physical Therapy to release to my insurance companies, employer insurance groups, health plans, Medicaid/Medicare Program, or any intermediaries, or Physicians in connection with a program of physical exercise, which may include Pilates, exercise, physical therapy, aerobic exercise and/or weight and resistance training (the "Program"), and any billing or collection agents of Core Fitness and Physical Therapy, any medical or financial records or other information concerning the Program to obtain reimbursement on my behalf for the services provided to me by Core Fitness and Physical Therapy and the Physicians associated with the Program. Further, I authorize Core Fitness and Physical Therapy to release any medical information concerning the Program to Physicians and clinicians associated with the Program who are my healthcare providers. I may revoke my authorization and consent at any time for any reason providing written notice to Core Fitness and Physical Therapy. This authorization shall not conflict with any internal policy regarding release of information, which will have priority. This authorization is not intended to allow the release of records regarding any treatment for services requiring a restricted release under State or Federal Law.

MY SIGNATURE BELOW INDICATES THAT I HAVE READ AND UNDERSTAND THIS AGREEMENT AND AGREE TO BE BOUND BY IT.

Print Name_____

Signature_____

Date_____

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Financial Policy

Welcome to our office! We are committed to providing you with the best possible care. If you have medical insurance, we are happy to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our financial policy. Payment, co-payment, deductibles, and coinsurance for services are due **each visit** for charges incurred up through your last visit. We accept cash, checks and all credit cards for payment. **Please understand that you are financially responsible for all charges, whether or not they are paid by Insurance.**

PLEASE READ CAREFULLY:

1. Your insurance is a contract between you, your employer and your insurance company. We are not a part to that contract. As a courtesy to our patients, we will bill your insurance carrier; however, we cannot guarantee payment in a timely manner. If for any reason, any portion of a bill is not paid by your insurance within 60 days from the date of service, you agree to make arrangements for prompt payment.
2. Any returned checks with be subject to a NSF fee of $25.00 which will be due at the next visit.
3. We have a 24 hour cancellation policy. If you cancel within the 24 hour period, or miss an appointment, our account will be charged a $50 fee.
4. If 3 or more visits are missed or cancelled without following our 24 cancellation policy, Core will automatically cancel all future appointments and notify referring physician.
5. Accounts that are past due will incur a finance charge at the rate of 10.5% annually.
6. Please see our credit card on file policy on the next page. Please note that we will run your card automatically if you have a copayment.

Again, our relationship is with you, not your insurance company. We realize that financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact our billing department promptly for assistance in the management of your account. If you have any questions about the above information or any uncertainty regarding insurance coverage, please don't hesitate to ask as we are here to help you.

I herby understand the above financial policy and agree to abide by it.

Patient Name_____ Date_____

Patient Signature_____ Date_____

(If patient is under the age of 18)
Parent/Legal Guardian Signature _____ Date _____

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Dry Needling Informed Consent

Please review the following information PRIOR to consenting to application of dry needling techniques which is recommended by your Physical Therapist as part of your plan of care.

Dry Needling is not acupuncture however it is also a technique that utilizes thin, solid filament needles. This needling technique is used specifically to treat myofascial trigger points, muscle spasms, or dysfunctional tissue. Like any medical procedure, there are possible complications. While these complications are uncommon, they do sometimes occur and must be considered prior to giving consent to the procedure.

- PAIN. When a needle is inserted in the correct location, it may briefly reproduce a muscular ache or a twitching response which indicates the technique should be effective in reducing the symptom. You may experience a muscular ache for one or two days followed by an expected improvement in your overall symptoms. It is extremely important that your Physical Therapist is made aware if you are feeling uncomfortable with the treatment.

- INFECTION. Any form of skin penetration creates an opportunity for bacteria to enter the system. In order to minimize the risk, your Physical Therapist will follow the proper disinfection procedures and will use only the sterile disposable single-use needles.

- BRUISING OR BLEEDING. On occasion you may experience a small painless bruise or blood spotting in the treated region. Bruising and the blood spotting of this nature would clear very quickly.

- DROWSINESS, FATIGUE AND AUTONOMIC RESPONSES. On occasion you may experience a feeling of tiredness, nausea, dizziness, sweating; if this occurs, you will be asked to avoid driving until the feeling has passes; Change in blood pressure, heart rate, flushing of the face or breathing rate are involuntary reflexes which may change temporarily as a result of dry needling; these occur rarely and should give no cause for concern.

- PNEUMOTHORAX. There have been approximately 100 reported cases worldwide of acupuncture needles puncturing a lung. This only occurs when needles are inserted too deeply or incorrectly. Pneumothorax is a serious medical condition requiring admission to hospital. Your Physical Therapist has been trained to avoid the lungs and limit needle depth to avoid this occurring.

I have read this form and I understand the risks involved with dry needling therapy. I have had the opportunity to ask questions and express any concerns, of which have been answered to my satisfaction. I also agree to advise my Physical Therapist of any and all changes in my physical condition whether or not I believe these changes will affect my treatment or plan of care. I consent to dry needling treatment provided by my Physical Therapist.

With my signature, I hereby consent to the performance of this procedure.

Signature: _____ Date: _____

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Dry Needling Consent and Request for Procedure

Dry needling is a technique used in physical therapy practice to treat pain and trigger points in muscles. It is an invasive procedure using a solid and thin monofilament needle for the treatment of pain and dysfunction of various body tissues.

As with any medical procedure, there are possible complications and while these are uncommon, they do sometimes occur and must be considered prior to giving consent to the procedure.

Adverse events may include infection, bleeding, pneumothorax, nerve lesions, increased pain, nausea, and fainting. Fortunately, all these complications are not fatal and are readily reversible.

All precautions will take place to prevent these from happening. The precautions include use of sterile needles and gloves, precautions in location of needling with landmarks checked/rechecked, proper hand washing techniques, a thorough medical screening, proper post-needling care, proper positioning, and constant communication between the patient and the clinician.

Patients are to inform their practitioner about conditions such as pregnancy use of blood thinners, or immunosuppressant medications prior to the treatment.

Dry needling is a technique used in physical therapy practice to treat trigger points in muscles. You should understand that this dry needling technique should not be confused with an acupuncture treatment performed by a licensed acupuncturist.

Patient's consent: I have read or had read to me the above; I understand the risks involved with dry needling. I have had the opportunity to ask any questions I had and all of my questions have been answered.

With my signature, I hereby consent to the performance of this procedure.

DO NOT SIGN UNLESS YOU HAVE READ AND THOROUGHLY UNDERSTAND THIS FORM.

Signature: _____ Date: _____

Physical Therapist Affirmation: I have explained the procedure indicated above and its intended risks and consequences to the patient who has indicated understanding thereof, and has consented to its performance.

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Credit Card Recurring Payment Authorization Form

I, *(full name)*_____ authorize **Core Fitness + Physical Therapy** to process payment on my Visa, MasterCard, American Express or Discover Card for services and/ or for any balance due that has not been paid 30 days after it is received. I also authorize Core Fitness + Physical Therapy to process payment for my copayment at each visit. I understand that if the appointment is missed or I do not follow the cancellation policy as specified, Core Fitness + Physical Therapy is authorized to charge my credit card $50 per occurrence.

Patient Name_____

Billing Address_____ Phone# _____

City_____ State_____ Zip _____ Email _____

Account Type: ❑ Visa ❑ MasterCard ❑ Amex ❑ Discover

Cardholder Name _____

Account Number _____

Expiration Date _____

CVV (3 digit number on back of Visa/MC, 4 digits on front of AMEX) _____

Signature_____ Date_____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the business in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. This payment authorization is for the type of bill indicated above. I certify that I am an authorized user of this credit card and that I will not dispute the scheduled payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form.