Navigate
Physical Therapy

3115 Lewis Ave (lower level)
Zion, IL 60099
Phone: 224.800.7564
Fax: 847.746.9144

Dear New Patient,

Welcome to Navigate Physical Therapy, PLLC. Thank you for choosing us as your partner in healthcare.

We at Navigate Physical Therapy, PLLC strive to provide you with the highest quality of one-on-one, personal physical therapy services. We believe that our role in your recovery from illness, injury, or surgery is to evaluate, treat, educate, and help navigate your path to improved mobility and less pain. We will work closely with your referring physician to help you achieve your goals. Your commitment to active participation in helping yourself will make an important difference in the outcomes you achieve with physical therapy. This commitment includes participating in your physical therapy appointments, performing your home exercise program, and following up with your referring physician.

We have partnered with American Medical Billing to provide billing services. If you have any questions regarding billing, please contact them at (630) 924-0156.

We know that you have choices in healthcare and we thank you for choosing Navigate Physical Therapy, PLLC for your physical therapy needs.

Becki Matteson

Becki Matteson, MPT

Owner, Navigate Physical Therapy, PLLC

Navigate Physical Therapy, PLLC

Last Name: _____ First: _____ Middle Initial: _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____ Mobile Phone: _____ Home Phone: _____

Social Security Number: _____ Date of birth: _____/_____/_____ Male/Female: _____

Referring Physician: _____ Physician's Phone Number: _____

Emergency Contact: _____Date of Injury/ Surgery (if known): _____/_____/_____

Insurance Information:

Type of Coverage for Treatment: Medicare ___ PPO ___ W/C ___ MVA ___ HMO ___

Medicare Patients Only: Are you under the care of a home health agency? Yes/No

If yes: From ___/___/____ To ___/___/____ Primary Care Physician last seen ___/___/____

Primary Insurance Carrier: _____ Phone:_____

Address: _____ City: _____ State: _____ Zip: _____

ID # _____ Group #_____

Policy Holder (if not self):_____ DOB: ___/___/____ Relationship:_____

Policy Holder's Employer: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Secondary Insurance Carrier: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

ID # _____ Group #_____

Policy Holder (if not self):_____ DOB: ___/___/____ Relationship: _____

Policy Holder's Employer: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Work Comp or Liable Party's Carrier: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Claim #:_____ Contact Person: _____

Attorney and Firm Name (if applicable): _____

Address: _____ City: _____ State: _____ Zip: _____

Contact Person: _____ Phone: _____

Authorization and Assignment: I hereby authorize my insurance carrier to make benefit payments directly to Navigate Physical Therapy, PLLC, on my behalf. I hereby acknowledge my financial responsibility for fees not paid by this assignment and agree to pay for any collection and/or legal fees incurred if my account becomes delinquent.

Signature: _____ Date: _____

Navigate Physical Therapy, PLLC Symptom and History Form

Name: _____ Date:_____

Pain:

1. Where is your pain? _____
2. What does it feel like? _____
3. What is your current level of pain? Scale 0 (no pain)- 10 (maximal pain)____ / 10
4. What is the highest your pain has been in the last week?_____/ 10
5. What is the lowest your pain has been in the last week?_____/10
6. What does your pain limit you from being able to do?_____

Medical and Social History:

1. Please circle if you have any of the following: Pacemaker, Heart Attack, Heart Disease, Seizures, Stroke, Epilepsy, Currently/Might Be Pregnant, Diabetes, Parkinson's, Alzheimer's, Fibromyalgia, Cancer, Lupus, Osteoarthritis, Rheumatoid Arthritis, Joint Replacement, Osteoporosis, Osteopenia, High Blood Pressure, High Cholesterol, On Blood Thinners, Smoker, Asthma, COPD/emphysema, Anxiety, Depression, Current Infection
2. Please list any other medical conditions:_____
   _____
3. Please list any medications that you are taking: _____
   _____
   _____
4. Have you had any falls? Yes/no. When? _____
5. Do you use an assistive device? Cane? Crutches? Walker? Wheelchair? Other_____
6. Have you had any surgeries? Please list: _____
   _____
   _____
7. What do you or did you do for a living? _____
   a. Full time? Part time? Light duty? Off due to injury? Retired?_____
8. Do you regularly exercise? Yes/No. If yes, what and how often:_____
9. **Social history** (please circle one in each category):
   a. House, apartment, condo, mobile home? Does it have stairs? Yes/no If yes, how many?_____
   b. Married, single, divorced, widowed?
   c. Live alone? With spouse? With children? With friends? With parents? Other _____
10. **Goals**: Please list your goals for physical therapy: (i.e. what would you like to be able to do that you cannot):
    a. _____
    b. _____
    c. _____

Navigate Physical Therapy, PLLC

Informed Consent for Treatment

By my signature, which appears below, I hereby grant my permission for and request that I be evaluated and treated by the physical therapist according to the plan of care developed by the physical therapist and prescribed by my physician in consultation with the therapist(s). I understand that the purpose of this program is to enhance my recovery from an illness, injury, or surgery. It has been explained to me that there exists the likelihood of changes in the treatment program as my condition changes and I hereby grant my permission for all modifications and changes to the treatment program deemed necessary by the therapist(s). The procedures and modalities to be used have been explained to me and I have had the opportunity to ask any questions I have had and acknowledge that I have received answers that are satisfactory to me. I understand that the success of this or any other medical treatment program depends on my involvement and cooperation with the program including regular attendance at all treatment sessions and conscientious follow through with any home exercises or procedures which may be prescribed by the therapist(s). I understand what is expected of me as a patient and agree to cooperate to the best of my ability. However, I understand that the practice of rehabilitation therapy is not an exact discipline and I acknowledge that no guarantees or warranties have been made to me regarding treatment and/or the treatment results from physical therapy. I hereby attest that I have read and agreed to all statements made above and that my participation in this physical therapy treatment program is fully voluntary.

Patient Signature: _____ Date: ____/____/_____

Witness Signature: _____ Date: ____/____/_____

Cancellation/Missed Appointment Policy

If you need to cancel please call no later than **24 hours** prior to your scheduled appointment date and time. If you are 15 or more minutes late to your appointment without consent of your therapist, the visit will be considered a missed visit. There will be a $50.00 fee billed to you personally if you do not provide at least a 24-hour notice of a cancellation or if you no-show for an appointment. Also, if you miss three consecutive scheduled appointments without calling to cancel or reschedule you will be discharged immediately from physical therapy. This policy will be enforced after your initial appointment. **By signing below, I agree to pay the fees outlined in this policy**.

Patient Signature: _____ Date: ____/____/_____

Witness Signature: _____ Date: ____/____/_____

Acknowledge of Receipt of Notice of Privacy Practices

I understand that under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") I have certain rights to privacy regarding my protected health information. I understand that this information can be used to: conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly; obtain payment from third-party payers; conduct normal healthcare operations such as assessments and physician certifications. I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* and that I may contact this organization at any time to obtain a current copy. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Signature: _____ Date: ____/____/_____

Witness Signature: _____ Date: ____/____/_____

Navigate Physical Therapy, PLLC

COVID-19/Infectious Diseases Liability Waiver

I acknowledge the contagious nature of the Coronavirus/COVID-19 and that the CDC and many other public health authorities recommend practicing social distancing. I further acknowledge that Navigate Physical Therapy, PLLC has put in place preventative measures to reduce the spread of COVID-19. I further acknowledge that Navigate Physical Therapy, PLLC cannot guarantee that I will not become infected with Coronavirus/COVID-19. I understand that the risk of becoming exposed to and/or infected by the COVID-19 may result from the actions, omissions, or negligence of myself and/or others. I voluntarily seek services provided by Navigate Physical Therapy, PLLC. I acknowledge that I must comply with all set procedures to reduce the likelihood of spread or exposure while attending my appointment. I attest that:

- I am not experiencing any symptom of illness such as cough, shortness of breath or difficulty breathing, fever, chills, sore throat, or new loss of taste or smell.
- I have not traveled internationally within the last 14 days.
- I have not traveled to a highly impacted area of the United States of America in the last 14 days.
- I do not believe that I have been exposed to someone with a suspected and/or confirmed case of COVID-19.
- I have not been diagnosed with COVID-19 and not yet cleared as non-contagious by public health authorities.

I hereby release and agree to hold Navigate Physical Therapy, PLLC harmless from and waive on behalf of myself, my heirs, and any personal representatives, all causes of action, claims, demands, damages, costs, expenses, and compensation for damage or loss to myself and/or property that may be caused by any act, or failure to act by Navigate Physical Therapy, PLLC, or that may otherwise arise in any way in connection with any services received from Navigate Physical Therapy, PLLC. I understand that this release discharges Navigate Physical Therapy, PLLC from any liability or claim that I, my heirs, or any personal representations may have against Navigate Physical Therapy, PLLC with respect to any bodily injury, illness, death, medical treatment, or property damage that may arise from, or in connection to, any services received from Navigate Physical Therapy, PLLC. This liability waiver and release extends to the PLLC together with owners and employees.

Patient Signature: _____ Date: ____/____/_____

Witness Signature: _____ Date: ____/____/_____

Electronic and Telephonic Communication

I understand and consent that Navigate Physical Therapy, PLLC may make calls and/or send text messages to any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me and/or the account holder. I understand and consent that these calls or text messages may include, but are not limited to, the use of prerecorded/artificial voice messages and/or automatic telephone dialing systems. I understand that I am not required to agree to his provision as a condition of receiving services and that my consent may be revoked at any time.

Initial: Yes _____ or No _____

I understand and consent that Navigate Physical Therapy, PLLC may send emails to me at any email address provided to Navigate Physical Therapy, PLLC and/or use other electronic means of communication to the extent permitted by law. I understand that I am not required to agree to this provision as a condition of receiving services and that my consent may be revoked at any time.

Initial: Yes _____ or No _____

Patient Signature: _____ Date: ____/____/_____

Witness Signature: _____ Date: ____/____/_____

Navigate Physical Therapy, PLLC

Authorization to Disclose Health Information

Patient Name:_____ Date of Birth: _____

1. I authorize the use or disclosure of the above-named individual's health information as described below. The following individual or organization is authorized to make the disclosure: Navigate Physical Therapy, PLLC at 3115 Lewis Avenue (Lower Level), Zion, IL 60099.
2. The type and amount of information to be used or disclosed is as follows (include dates where appropriate):

   □ Evaluation(s)

   □ Progress Note(s)

   □ Most recent history and physical

   □ Most recent discharge summary

   □ Entire record

   □ Other _____

   _____
3. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
4. This information may be disclosed to and used by the following individual or organization:
   _____
   Address _____
5. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Navigate Physical Therapy, PLLC. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.
6. I understand that authorizing this information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I will contact Rebecca Matteson at (224) 800-7564.

   Signature of Patient or Legal Representative:_____ Date: _____

   If Signed by Legal Representative, Relationship to Patient: _____

   Signature of Witness: _____ Date: _____

Navigate Physical Therapy, PLLC

Notice of Health Information Practices

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Understanding Your Health Record/Information

Each time you visit a healthcare provider, hospital, or physician a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment. This information, often referred to as your health or medical record serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third-party payer can verify that services billed were actually provided
- A tool in educating health professionals
- A source of data for medical research
- A source of information for public health officials charged with improving the health of the nation
- A source of data for facility planning and marketing
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Your Health Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- Obtain a paper copy of the notice of information practices upon request
- Inspect and copy your health record as provided for in 45 CFR 164.525
- Amend your health record as provided in 45 CFR 164.528
- Obtain an accounting of disclosures of your health information by alternative means or alternative locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities

This organization is required to:

- Maintain the privacy of your health information
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

We reserve the right to change our practices and to make new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us.

We will not disclose your health information without your authorization, except as described in this notice.

For More Information or to Report a Problem

If you have questions and would like more information, you may contact our Compliance Officer at (224) 800-7564. If you believe your privacy rights have been violated, you can file a complaint with the Compliance Officer or with the Secretary of Health and Human services. There will be no retaliation for filing a complaint.

Navigate Physical Therapy, PLLC

Examples of Disclosures for Treatment, Payment, and Health Operations

We will use your health information for treatment: Information obtained by your physical therapist will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his/her expectations of your physical therapist. Your physical therapist will then record the actions that he/she took and his/her observations. This will allow your physician to know how you are responding to treatment. We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in your treatment once you have been discharged from therapy.

We will use your health information for payment: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnoses, procedures, and supplies used.

We will use your health information for regular business operations: Members of the medial staff, the compliance officer, or other members of our physical therapy staff may use the information in your health record to assess the care and outcomes in your case and others like it. The information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business Associates: There are some services provided in our organization through contacts with business associates. Examples include our billing services. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked them to do. To protect your information, however, we require business associates to appropriately safeguard your information.

Communication with family: Health professionals, using their best judgement, may disclose to a family member, other relative, close personal friend, or any other person you identify health information relevant to that person's involvement in your care or payment relating to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law Enforcement: We may disclose information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority, or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

Effective Date: 05/22/2020