



## Medical Insurance Registration Form (page 1)

WELCOME TO OUR OFFICE

By completing this patient information form, you will help us to serve you more efficiently.  
Should you have any questions concerning our professional services or office procedures, please ask.

PLEASE PRINT – COMPLETE ALL INFORMATION

Patient's Name: \_\_\_\_\_ Date \_\_\_\_\_

Marital Status: Single \_\_\_ Married \_\_\_ Separated \_\_\_ Widowed \_\_\_ Divorced \_\_\_

Name of Spouse (or parents of child): \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_

Alternate Phone (Cell) (\_\_\_\_) \_\_\_\_\_

Employer (patient or parents) \_\_\_\_\_

Occupation \_\_\_\_\_ How Long \_\_\_\_\_ Work Phone(\_\_\_\_) \_\_\_\_\_

Work Address \_\_\_\_\_

Drivers License # \_\_\_\_\_ Patient Social Security # \_\_\_\_\_

Whom may we thank for referring you to us \_\_\_\_\_

Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

Name of insured \_\_\_\_\_ Date of Birth of insured \_\_\_\_\_

Patient relationship to insured \_\_\_\_\_

Please check your preferred method of payment

Check \_\_\_\_\_ Cash \_\_\_\_\_ MasterCard/Visa \_\_\_\_\_

Please indicate school, physician, or other persons to whom you would like a written report sent:

Physician \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_

IF YOU NEED TO CANCEL AN APPOINTMENT OR RESCHEDULE AN APPOINTMENT, PLEASE  
DO SO WITH AT LEAST 24 HOURS NOTICE. FAILURE TO COMPLY WITH OUR 24 HOUR  
NOTICE POLICY WILL RESULT IN A \$20 NO SHOW/CANCELLATION FEE.

Signed: \_\_\_\_\_

**Medical Insurance Registration Form (page 2)**

PERTINENT MEDICAL INFORMATION

Work related injury? YES NO      Date of Injury: \_\_\_\_\_ Are you currently working? YES NO

Full Time: \_\_\_\_\_ Part Time: \_\_\_\_\_

Motor Vehicle Accident? YES NO      Date of Accident: \_\_\_\_\_

Sports Injury: YES NO      Date of Injury: \_\_\_\_\_ Sport: \_\_\_\_\_

Other: \_\_\_\_\_  
 \_\_\_\_\_

Brief Description of Current Symptoms: \_\_\_\_\_  
 \_\_\_\_\_

Have you received treatment for these symptoms? YES NO

If YES what type: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

What type of testing have you received for this injury:

X-Ray MRI CT Scan Bone Scan      Results: \_\_\_\_\_

Have you had physical/occupational therapy within the last calendar year? YES NO

If YES, was it for your current condition? YES NO

Approximately how many treatments have you received this calendar year? \_\_\_\_\_

INDICATE IF YOU HAVE ANY OF THE FOLLOWING BY CIRCLING THE CORRECT RESPONSE:

Diabetes	YES	NO	Stroke	YES	NO
Chest pain	YES	NO	Seizures	YES	NO
Heart Disease	YES	NO	Metal Implants	YES	NO
Pacemaker	YES	NO	Dizziness	YES	NO
Headaches	YES	NO	Fractures	YES	NO
Kidney Problems	YES	NO	Skin Allergies	YES	NO
Are you pregnant?	YES	NO	Nausea/Vomiting	YES	NO
Cancer	YES	NO	Asthma	YES	NO
Arthritis	YES	NO	Hypoglycemia	YES	NO
AIDS/HIV	YES	NO	Bladder problems	YES	NO
Latex Sensitivity	YES	NO	Tumors	YES	NO
Hepatitis (A,B,C)	YES	NO	Nervous/Anxious	YES	NO
Psychiatric/Psychological Care	YES	NO			

**Medical Insurance Registration Form (page 3)**

If you answered yes to any of the previous, please explain: \_\_\_\_\_

\_\_\_\_\_

Recent Surgery? Explain \_\_\_\_\_

\_\_\_\_\_

Are you currently taking medication: YES NO If yes, please list medications:

\_\_\_\_\_

Please list any known allergies: \_\_\_\_\_

\_\_\_\_\_

**INSURANCE**

It is the patient's responsibility to contact his/her insurance company and obtain benefit approval and coverages prior to the first visit. WE ARE NOT RESPONSIBLE FOR CALLING YOUR INSURANCE COMPANY FOR VERIFICATION. Here is the information you will need when you call:

Praxis Tax ID #20-1444683

Michael Kordecki IL License #070-00458

Are you in network? Is there a copay? All copays are due at time of service . Are there a maximum number of visits allowed per calendar year? Is durable medical equipment covered? You are responsible for all durable goods at time of acceptance of goods. Do you need pre-certification? If yes, please let us know prior to your appointment, as this must be done by our office.

We will make a copy of your insurance card when you come in and all bills will be submitted by Praxis.

Our financial policy is as stated:

- All co-pays and patient responsibility portions are due at time of service (when applicable).
- Payment is due in full at time of service unless other arrangements have been made. You are responsible for all durable goods at time of acceptance of goods. We accept cash, checks, and some types of credit cards. Praxis will set up a payment plan for balances on an individual basis, as deemed necessary.

I have read and understand the terms of my benefits I have just obtained. I know that verification is not a guarantee of payment and that I am responsible for any unpaid balances left after my insurance.

I have read the above policies and agree to them. I authorize Praxis Physical Therapy to provide me with physical therapy services and to furnish further information to my insurance company and my physician concerning my injury and treatment. I understand that I am financially responsible for payment of all services as described above.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_



## Praxis Financial Policy

Thank you for choosing Praxis Physical Therapy and Human Performance as your health care provider. We are committed to the successful treatment of your condition. Please understand that payment of your bill is considered part of your treatment. Your clear understanding of our Financial Policy is important to our professional relationship. Please contact our Practice Administrator if you have any questions, 847-724-7200.

Full payment is due at the time of service. We accept cash, check, Visa/MasterCard, and Discover. All patients must complete our "Patient Registration Form" and other related forms. For cases which we bill insurance directly, we must have a copy of the insurance ID card. If payment is not received from the insurance carrier or other responsible third party in 90 days, we have the right to bill you directly. Please notify us immediately of any changes in your insurance or coverage. 24-hour notice is required for copies of medical records and there may be a nominal fee.

**UCR (Usual and Customary Rates)** We are committed to provide the best treatment possible for our patients and we charge what is usual and customary for our area. You are responsible for payment in full regardless of any insurance company's arbitrary determination of UCR rates.

**Self pay.** We expect payment at time of service unless prior arrangements have been made.

**HMO/PPO** All co-payments are due at the time of service. If you do not know your co-pay you may use our telephone to call your insurance provider. We are members of many, but not all, plans. You are responsible for verifying in or out of network providers for your plan. If you are an HMO member you will not be billed as long as we have the necessary referrals. PPO patients will only be responsible for their co-payments and co-insurance as long as they have verified with their insurance that Praxis Physical Therapy and Human Performance is in their plan.

**Workers Compensation** If you are here as a result of work related injury, we will require information regarding both health insurance and your employer's Workers' Compensation insurance. We will also need to verify that your employer assumes responsibility for charges incurred. If we cannot verify responsibility or we are unable to obtain information on your employer's Worker's Compensation insurance, as a courtesy we will bill your health insurance carrier. If payment is not received from these third parties within 60 days, we have the right to bill you directly.

**Accident Claims** If you are here as a result of an accident claim, we will require information regarding both health insurance and accident insurance. If payment is not received from these third parties within 30 days, we have the right to bill you directly.

**Medicare** We accept Medicare assignment. As a Medicare patient you are responsible only for the difference between the approved charge and the amount Medicare pays and, of course, your deductible. If you have supplemental insurance we will bill it directly for you. You will receive a bill after your insurance has paid.

I understand that if the office agrees to bill insurance as a courtesy, I must submit information as needed to ensure payment for services rendered to me. I understand that I am ultimately responsible for payment for all services.

Printed Name of Patient \_\_\_\_\_

Signature of Patient or Responsible Party \_\_\_\_\_

Date \_\_\_\_\_