

Creative Therapeutics 3300 Resource Parkway#5 DeKalb IL 60115

Thank you for choosing our office!! In order to serve you properly, we need the following information. All information will be kept confidential.

Please Print

Patient Name: Last, First, Middle, Initial				Today's Date:	
Home address:			City:		State:
					Zip:
Home phone:		Work Phone	Cell phone	Email address:	
Birth date:		Social Security #:		Height :	Weight:
					Gender: M F
Circle appropriate: Minor Single Married Divorced Separated Widowed					
Person to contact in case of emergency:			Their Relationship to you:		Their Phone Number:
Patient's Occupation:		Employment status		Family doctor:	
		Referring physician			
How did you hear about us?					
If we need to reach you can we email or use your cell #?					
May we send you our email newsletter?					

Insurance information:

Insurance company:			Spouse SS# if policy holder		
Patient's (or parent/guardian's) employer:					
Business Address:			City:		State:
					Zip:
Spouse (or parent/guardian's) Name:			Spouse's Occupation:		
Spouse (or parent/guardian's) Employer:			Spouse's Work phone:		
Spouse birth date		Policy holder		Policy #	
Relation to insured			Insurance phone number:		
Secondary insurance			Secondary insurance policy number		

I certify that the above information is accurate.

Signature _____ Date _____

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If this is a worker's comp claim please complete the following

Did you report this incident to your employer? yes no	Date of injury	Company Contact phone number
Is your employer aware that you are seeking treatment? yes no	Company contact person	
Place of employment	Human resources representative for company	
Insurance company	Insurance company phone number	
Case number	Please add any information we should know about case	

If this is a motor vehicle accident please fill out the following information

Date of injury	State the accident took place
Insurance company	Policy holder
Policy number	Claim number
Contact person	Contact phone number
Is this your insurance or other parties insurance?	3 rd party name
3 rd party phone	3 rd party address
3 rd party City, state, zip	

Important information regarding your accident: It is unfortunate you have been hurt in a motor vehicle accident. The insurance company for the responsible party appears to be liable for your treatment; however, you are responsible to us for the payment of your treatment should your insurance company deny payment. If your insurance company is not paying your claims as you receive treatment (holding for all treatment to be finished and signed off on) Creative Therapeutics and Acupuncture Health Center require payment at each appointment. Full payment would be appreciated, but you must pay at least a portion of your payment for each treatment. Any charges that are not paid by your insurance company in a timely manner will be billed and due from you.

Signature _____ date _____

PAST MEDICAL HISTORY

NAME _____ AGE _____

HAVE YOU EVER HAD THE FOLLOWING CONDITIONS? (PLEASE CHECK)

	YES	NO		YES	NO
Heart Trouble	_____	_____	Asthma	_____	_____
High Blood Pressure	_____	_____	Emphysema	_____	_____
Diabetes	_____	_____	Back Injury	_____	_____
Headaches	_____	_____	Arthritis	_____	_____
Dizzy Spells	_____	_____	Bleeding Disorder	_____	_____
Fainting Spells	_____	_____	Fracture	_____	_____
Epilepsy	_____	_____	Cancer	_____	_____
Stroke	_____	_____	Pacemaker	_____	_____

REGARDING YOUR PRESENT INJURY OR CONDITION:

Date of Injury/condition _____

How did the injury occur? _____

Have you been hospitalized for the present problem? Yes _____ No _____

Have you had surgery for the present problem? Yes _____ No _____
Date _____

Have you had therapy for the current problem? Yes _____ No _____

If so, Please summarize the results _____

Date last seen by a physician for the present problem? _____ Next appointment date? _____

Are you being seen by any other physician? _____

Are you on medication? Yes _____ No _____. If yes, please state type of medication

PAST MEDICAL HISTORY

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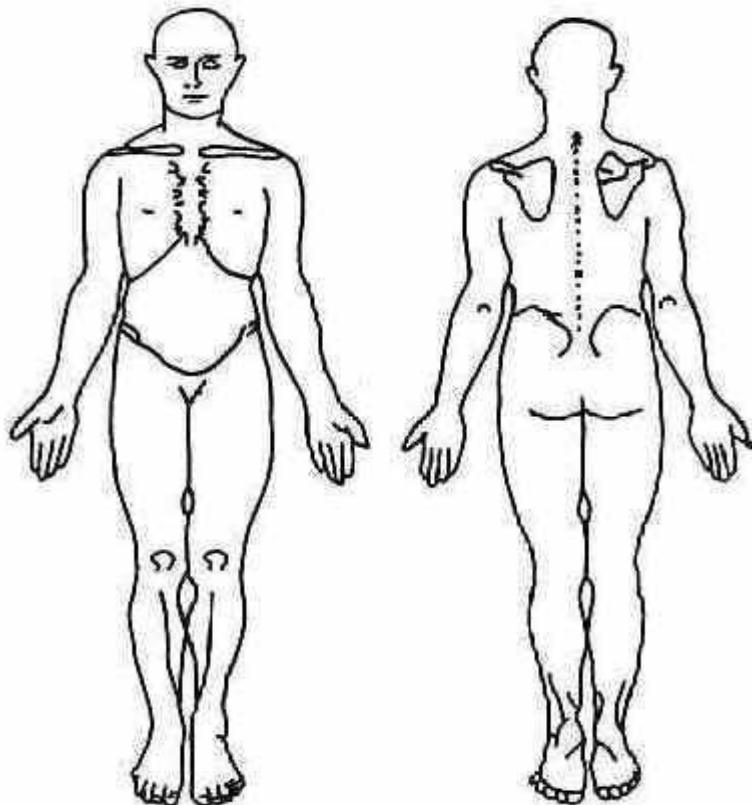
Which of the following best describes your symptoms? Sharp _____ Dull _____

Burning _____ Numbness _____ Constant _____ Intermittent _____

Pins and Needles _____ Other _____

Rate your pain using a scale of 1 – 10. (1 being the lowest, 10 being the most pain) _____

Please shade in your painful area:



Signature of person completing form _____ Date _____

FINANCIAL POLICY

Communication with our clients regarding our financial policy assists us in providing the best possible service to you. Please read the following. Your signature is required at the bottom of the page. Thank you.

- **Private Pay** – (clients without insurance) Full payment is required when services are rendered to continue treatment OR payment arrangements need to be agreed upon.
Insurance Company Reimbursement – **Clients are required to contact their insurance company to verify their deductible status and the amount of coverage for physical/occupational therapy available to them.** We will also be contacting your insurance company to verify your coverage. **It is important to remember that what the insurance company tells us is not a GUARANTEE of payment from them.**
- **Deductible and Co-payment** - If you have not previously met your deductible, payment is due in full for your initial evaluation at the time of your first visit. If you have not met your deductible, you will be required to pay the full amount of each visit until you have met it. **We require your co-payment or co- insurance at the time of service.** If you do not know what your co-insurance is, a minimum of 20% is due at the time of service. Any charges that your insurance company does not pay for or denies will be the patient's responsibility.
- **Purchasing products** – **payment for all products are the patient's responsibility.** Payment for products is due at the time of purchase. As a courtesy to you, we will bill your insurance company. If your insurance company does pay for the product, we will credit/refund your account.
- **Worker's Compensation** – All pre-authorized bills will be sent directly to your Worker's Compensation carrier. **If your claim is denied or disputed, you will be responsible for payment** and a payment plan will be arranged.
- **Auto Accident** - You must supply us with the insurance company who is responsible and a contact person. **If they do not pay in a timely manner, or are waiting until the accident is completely settled to make payment - you will be responsible for payment at the time of service.**

AGREEMENT TO PAY

I understand that the agreement with my health insurance, worker's comp carrier or auto accident insurance is an agreement between them and me. I take full responsibility for payment of all charges for professional services rendered. I understand the financial policy detailed above. **I understand that I am responsible for all charges regardless of my existing medical coverage.**

A fee of \$25.00 will be charged for cancellation of my appointment without 12 hours notice or failure to attend a scheduled appointment. NSF checks will be charged a \$25.00 fee.

Consent for Treatment/Release of Insurance Assignment Medical Information

YES _____ NO _____ I authorize any and all therapy service that the provider feels necessary or advisable in conjunction with my referral.

YES _____ NO _____ I assign payment of medical benefits directly to Creative Therapeutics, Ltd.

YES _____ NO _____ I hereby authorize Creative Therapeutics, Ltd. to release to my insurance company, health plan, or insurance group, any medical records or information concerning the treatment to obtain reimbursement on my behalf for the treatment or service provided by Creative Therapeutics, Ltd. I understand that I may revoke the consent to release information to third parties at any time and that the provision of services is not conditioned on my agreement to disclose information to the parties. If I revoke my consent, I will be responsible for paying for all services rendered by Creative Therapeutics, Ltd.

I have read, understand and agree to this financial agreement.

SIGNATURE

DATE