ENDURANCE
Physical Therapy
Endurance-PT.com | Phone (224) 300-6158 | Fax (847) 400-0795

INTAKE AND CONSENT FORM

Patient Name:		**Date:**	
Address:		**Date of Birth:**	
Phone Number:		**Email:**	

Email/Phone Consent: By providing your email address and phone number you are giving consent to receive email/text statements and other correspondence which may include financial or diagnosis information. You acknowledge that electronic transmissions may not be a secure form of communication.

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Initial

Emergency Contact:		**Emergency Contact Phone Number:**	
Referring Physician:		**Reason For Visit:**	

Payment: All co-payments and self–pay services are due at the time of service. Patient acknowledges that in consideration of the services provided to you by Endurance Physical Therapy PLLC ("Endurance Physical Therapy") patient is financially responsible for the payment of their bill. Patient acknowledges that it is their responsibility to provide Endurance Physical Therapy with current insurance information. Your health insurance plan may provide that all or a portion of the charges and balance will remain your personal responsibility, such as your deductible, co-payment, co-insurance or charges not covered or denied by my health insurance. In the event that insurance does not cover a session you are responsible to pay the self pay rate of $175 for an evaluation and/or $150 for a session. You agree to pay any such amounts which are your responsibility. You understand that Endurance Physical Therapy will bill your personal insurance carrier as a courtesy, but that you are ultimately responsible for any amounts owed. Please select the payment type below:

Insurance Company		**Policyholder (Name and D.O.B)**	
ID#		**Group #**	
Payment Type:	**Cash**	**Credit Card**	**Check**

If you intend on using a credit card, please complete the attached credit card authorization form

Cancelation: Your appointment time has been reserved just for you. Keeping all your appointments is an integral part of your recovery. If you do need to cancel an appointment,

please be aware of our requirement of a least 24-hour notice. Failure to cancel your appointment with more than 24-hour notice will result in a $75.00 fee. Insurance will not pay for this fee.

Consent to Treat: I hereby authorize and give my consent to Endurance Physical Therapy to provide me with Physical Therapy Services that fall under the scope of practice in the State of Illinois.

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Initial

HIPAA Consent: The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. There are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. As a result, Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in a safe manner and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be used for administrative purposes. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties. You agree to bring any concerns or complaints regarding privacy to the attention of the physical therapist. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services. We agree to provide patients with access to their records in accordance with state and federal laws. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I hereby consent, acknowledge and agree to the terms set forth in the HIPAA Consent and any subsequent changes. I understands that this consent shall remain in force from this time forward.

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Initial

Print Name:_____

Signature: _____ Date:_____

CREDIT CARD AUTHORIZATION FORM

I authorize Endurance Physical Therapy to charge my credit card for an outstanding invoice after 5 days of receiving the invoice. All self–pay services will be charged at the time of service.

Print Name:_____

Signature: _____ Date:_____

Credit Card Information

CC Type:	
Cardholder Name:	
CC Number:	
Expiration Date:	
CVC:	
Billing Address:	