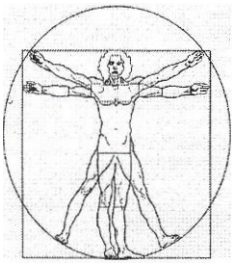


Lake County Physical Therapy LLC

1721 Moon Lake Boulevard Suite 105, Hoffman Estates, IL 60169 224-653-9989

511E Hawley St, Mundelein, IL 60060 847-543-7604/847-201-7612

3535 E New York St, Suite 117 Aurora, IL 60504 630-978-8763

Dear Valued Client:

Thank you for choosing **Lake County Physical Therapy LLC** for your physical therapy needs. We appreciate your business and look forward to exceeding your expectations. If you have any questions, please do not hesitate to ask the therapist or staff. We look forward to partnering with you on your road to full recovery.

The following pages are for you to fill out legibly and accurately. The first page is a signature page that you have seen a copy of the HIPPA Notice of Privacy Practice. If you wish to have a written copy, please ask our staff. The second page is for billing and demographic information. The third page is a questionnaire regarding your medical history. And last is a page for you to map your area(s) of pain on the drawing.

It is very important that you maintain your scheduled appointments and not stop coming when you start to feel a little better. Discontinuing the therapy could hurt you in the long run. If you need to reschedule your appointment, please give us at least 24 hour notice or you may be subject to a no-show/cancellation charge of $75.00.

Co-payments are expected at the time of service. You will be advised of your co-pay after we verify your insurance. We understand that co-pays can be significant. If you cannot make full payment for your co-pays at the time of service, please contact our billing department to make arrangements.

Please inform us when you have an appointment with your referring physician so we can update them on your progress.

We encourage you to contact your insurance company to verify your coverage and benefits.

We pledge to give you prompt, efficient, courteous service rendered by a licensed Physical Therapist. We welcome your comments and suggestions and want to take this opportunity to welcome you to your first therapy session.

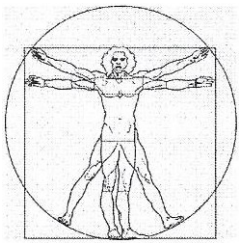
Sincerely,
The Staff of Lake County Physical Therapy

——— Is your condition/injury the result of a motor vehicle accident/a work related accident/or any other accident?.....Yes/ No If yes, date:_____

———————————— (PRINT NAME) have read this page and agree with the requirements stated and acknowledge responsibility for the above items.

———————————————————————— Signature_____Date

Allow Us To Exceed Your Highest Expectations



Lake County Physical Therapy LLC

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____,

have received the Notice of Privacy Practices from Lake County Physical Therapy, LLC.

_____ _____
Signature Date

In lieu of patient signature, I _____

a staff member of Lake County Physical Therapy, state that _____

has been given our current Notice of Privacy Practices.

_____ _____
Signature Date

Allow Us To Exceed Your Highest Expectation

LAKE COUNTY PHYSICAL THERAPY, LLC

(PLEASE PRINT CLEARLY)

First Name_____ Last Name _____

Date of Birth_____ Social Security# _____

Email Address: _____

(This is needed so we can send you newsletters, your therapy information or updates. **This will never be sold or shared!**)

Address _____

City_____ State_____ Zip_____

Home Phone# _____ Work Phone #_____

Cellphone# _____ O Male O Female

O Single O Married O Divorced O Widowed O Separated Onset Date_____

Employer_____ Phone._____

Referring Physician_____ Physician Phone#_____

Primary Care Physician_____ P.C.P. Phone#_____

Insurance Information

Primary Coverage Insurance_____

Guarantor Name_____ Relationship_____

Card Holder's $$#_____ Card Holder Birth Dare_____

Address_____

City_____ State_____ Zip_____

Home Phone#_____ Work Phone #_____

Cell Phone#_____ Employer Phone._____

Work Company Name/Address_____

Secondary Coverage Insurance_____

Guarantor Name_____ Relationship _____

Card Holder'sSS#_____ Card Holder Birth Date._____

Address_____

City_____ State_____ Zip_____

Home Phone#_____ Work Phone#_____

Cell Phone#_____ Employer Phone _____

Work Company Name/Address_____

IT IS YOUR RESPONSIBILITY TO INFORM US IF YOUR COVERAGE IS CONTINGENT UPON A SECOND OPINION OR PRIOR APPROVAL OF YOUR INSURANCE CARRIER.

I hereby authorize Lake County Physical Therapy LLC to perform treatments and procedures that they consider necessary for my benefit, upon consultation with my representative or me. I understand that I am financially responsible for any balance not covered by insurance. *I understand that there may be a $75.00 no show/cancellation charge if I fail to show up or call 24 hours in advance.*

Medicare Patient's Certification. Authorization to Release Information, Payment Request

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or any Medicare claim. I request that payment of the authorized benefits be made to Lake County Physical Therapy LLC on my behalf.

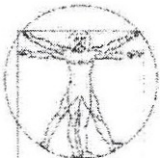
Insurance Patient's Certification; Authorization to Release Information, Payment Request

I certify that the information given by me in applying for payment under the provisions of my medical .insurance is correct. I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits to Lake County Physical Therapy LLC.

Patient Signature or Authorized Representative_____ Date_____

LAKE COUNTY PHYSICAL THERAPY LLC

Intake Package



Name: Age:_____Height: Weight:__lbs

Leisure activities, including exercise routines: _____

Occupation, including activities that comprise your workday:_____

Date you last saw your doctor: Reason: _____

Are you on a work restriction from your doctor? Yes No

Do you smoke? Yes No Do you have a pacemaker? Yes No

FOR WOMEN: Are you currently pregnant or think you might be pregnant? Yes No

ALLERGIES: List any medication(s)/products you are allergic to: _____

Have you RECENTLY noted any of the following (circle all that apply)?

fatigue	numbness or tingling	constipation
fever/chills/sweats	muscle weakness	diarrhea
nausea/vomiting	dizziness/Lighthead edness	shortness of breath
weight loss/gain	heartburn/indigestion	fainting
difficulty with balance and walking	difficulty swallowing	double vision
falls	changes in bowel or bladder function	headaches
difficulty talking	changes in urine or stool color	night pains
morning stiffness lasting more than 1hour	palpitations with slight exertion	incontinence

Have you EVER been diagnosed with any of the following conditions (circle all that apply)?

cancer	depression	thyroid problems
heart problems	lung problems / COPD	diabetes
chest pain/angina	tuberculosis	osteoporosis
high blood pressure	asthma	multiple sclerosis
circulation problems	pneumonia	rheumatoid arthritis
blood clots	other arthritic condition	eye problem/infection
stroke	bladder/urinary tract infection	GI ulcers
anemia	kidney problem/infection	liver problems
bone or joint infection or fracture	sexually transmitted disease/HIV	hepatitis
chemical dependency (i.e.• alcoholism)	pelvic inflammatory disease	epilepsy

During the past month have you been feeling down, depressed or hopeless? YES NO

During the past month have you been bothered by having little interest or pleasure in doing things? YES NO

Is this something with which you would like help? YES YES,BUT NOT TODAY NO

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? YES NO

Please list any medications you are currently taking (INCLUDING pills, injections, and/or skin patches):

1._____ 2._____ 3._____

4._____ 5._____ 6._____

Have you ever taken steroid medications for any medical conditions? YES NO

Have you ever taken blood thinning or anticoagulant medications for any medical conditions? YES NO

Have you taken antibiotics in the past 3 months? YES NO If yes why? _____

Please list any past surgeries or other medical conditions including dates diagnosed :

1._____ 2._____ 3._____

When did your present symptoms start and how?_ _____

What do you think caused your symptoms? _____

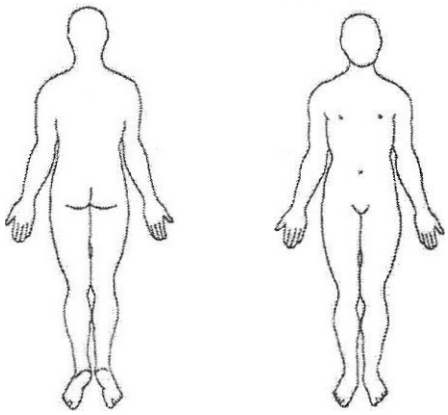
My symptoms are currently: • Getting Better • Getting Worse • Staying about the same

I should not do physical activities that might make my pain worse: • Disagree • Unsure • Agree

Treatment received so far for this problem (chiropractic, injections, etc.) _____

Please list special tests performed for this problem (x-ray, MRI, blood tests, etc.) _____

Have you ever bad this problem before: • Yes • No When._____ Treatment received_____



My symptoms currently: • Come and go • Are Constant • Are c-0nstant, but change with activity
Does taking a deep breath or twisting your back aggravate your symptoms'? YES NO
Does eating foods aggravate your symptoms'! YES NO

Aggravating Factors: Identify up to 3 important positions or activities that make your symptoms worse:

1. _____
2. _____
3. _____

Easing Factors: Identify up to 3 important positions or activities that make your symptoms better:

1. _____
2. _____
3. _____

How are you currently able to sleep at night due to your symptoms?

• No problem sleeping • Difficulty falling asleep • Awakened by pain • Sleep only with medication

When are your symptoms worst'? • Morning • Afternoon • Evening • Night • After exercise
When are your symptoms the best? • Morning • Afternoon Evening • Night • After exercise

Using the 0 to 10 pain scale, with 0 being *"no pain"* and 10 being the *"worst pain imaginable"* please circle:

Your current level of pain while completing this survey: I 2 3 4 S 6 7 8 9 10

The best your pain has been during the past 24 hours: I 2 3 4 5 6 7 8 9 I0

The worst your pain has been during the past 24 hours: I 2 3 4 5 6 7 8 9 I0

Please list your goals for your physical therapy treatment = _____