Kirk Center for Healthy Living
Therapy for Pelvic Pain, Incontinence, Infertility and Gastrointestinal Disorders

16618 W 159th St, Suite 401 & 402, Lockport, IL 60441
Phone: **(815) 838-0529** ❖ Fax: **(815) 838-0652**
Website: **kc4hl.com**

Patient Intake Form

Name: _____ Referral Date: _____ Height: _____ Weight: _____

Address: _____ City: _____ State & Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Date of Birth: _____ E-mail: _____

In case of emergency, contact: _____ Phone: _____

How did you hear about us: _____

Have you received any home health care within the past six months? YES ◯ NO ◯

Referring Physician: _____ City: _____ Phone: _____

Is there someone else that you would like us to send this information to?

Physician: _____ City: _____ Phone: _____

Diagnosis / Complaint: _____

RESPONSIBLE PARTY / PARENT / LEGAL GUARDIAN (if applicable)

Name: _____ Relationship: _____

Date of Birth: _____ Phone: _____

Address: _____ City: _____ State & Zip: _____

EMPLOYER INFORMATION

Employer Name: _____ Occupation: _____

Address: _____

Phone: _____ Contact Person: _____ Attorney: _____

PAST SURGERIES

Description: _____ Date: _____

Description: _____ Date: _____

Description: _____ Date: _____

Description: _____ Date: _____

PAST CONDITIONS / DISEASES / INJURIES / INFECTIONS

Description: _____ Date: _____

Description: _____ Date: _____

Description: _____ Date: _____

Description: _____ Date: _____

OTHER INFORMATION

Allergies: _____

Date of last pelvic / prostate exam: _____ Results: _____

Date of last mammogram: _____ Results: _____

Date of last dexascan / bone density test: _____ Results: _____

Date and results of any other recent tests: _____

Activity level / work / hobbies: _____

Severity of this condition (0=NO PROBLEMS – 10=UNBEARABLE): _____

Your goal from therapy: _____

_____

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PATIENT SERVICES AGREEMENT

PATIENT NAME: _____

INSURANCE BENEFITS: After my deductible of $_____ has been met, estimated per visit amount to be paid by me will be $_____. I understand that I am responsible for the unmet portion of my deductible, and all charges that are not covered by my insurance company. I guarantee payment of my account in full to Kirk Center for Healthy Living, P.C. ("Kirk Center") and understand that I can make payment arrangements prior to my discharge from therapy.

ASSIGNMENT OF BENEFITS: I authorize payment of benefits be made directly to Kirk Center for Healthy Living for services rendered. I guarantee that I will immediately reimburse Kirk Center for Healthy Living for any benefits assigned to me.

PAYMENT GUARANTY: I UNDERSTAND THAT I AM RESPONSIBLE TO PAY FOR ALL SERVICES RENDERED BY KIRK CENTER WHICH ARE NOT PAID BY MY INSURANCE. I expressly guaranty payment of this account with Kirk Center, and agree to pay all charges that remain unpaid by my insurance company within 30 days of the invoice date for those services. Interest at the rate of 1.5% per month, or portion of a month, will be added to any past due balance. I also agree to pay all expenses incurred by Kirk Center, including reasonable attorney fees, to collect any past due balance owed to Kirk Center.

RELEASE OF INFORMATION: I authorize Kirk Center to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, related healthcare providers, assignees and/or beneficiaries and all other related persons. Information without patient identifiers may be used for quality assurance purposes.

PERMISSION FOR MESSAGES: I authorize Kirk Center to leave messages -

About my treatment:

☐ on my voicemail or answering machine at my home
☐ on my voicemail on my cell phone
☐ on my voicemail at my work
☐ with another person

About my appointment times:

☐ on my voicemail or answering machine at my home
☐ on my voicemail on my cell phone
☐ on my voicemail at my work
☐ with another person

I have read this agreement and understand my obligations

_____ _____
Patient/Insured's Signature Date

_____ _____
Patient Address Preferred Phone

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DOCUMENTATION OF CURRENT MEDICATIONS

Use the below grid to document your current list of medications. This list ***must*** include ALL prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND ***must*** contain the medications' name, dosage, frequency and route of administration (oral, topical, suppository, inhalant, intravenous).

Medication / Supplement	***Dosage***	***Frequency***	***Route of Administration***

I do hereby attest that this information is true, accurate and complete to the best of my knowledge.

_____ _____
Patient/Guardian Signature *Date*

I have reviewed the above current medication list with the patient/guardian and it is to the best of my knowledge accurate as of the below signed date.

_____ _____
Therapist Signature *Date*

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CREDIT CARD AUTHORIZATION – (OPTIONAL)

I authorize Kirk Center for Healthy Living, PC, to bill the following credit card for services, missed appointments, deductibles, co-insurance or co-pays that have not been paid by my insurance carrier. I understand Kirk Center for Healthy Living, PC, will bill my insurance company and that my credit card may be charged after insurance payment is received. I understand that if my credit card is declined, a $50.00 fee will be posted to my account. If I fail to respond to monthly statements, collection action may be taken:

_____
Name of Patient

This authorization is to remain in effect until I cancel it in writing.

The payments I am authorizing are:

- ☐ Account delinquency of 75 days
- ☐ Monthly balance billing
- ☐ Each Visit

For your convenience we accept personal checks, **Visa**, **MasterCard, Discover and Amex**.

Card Type	Card Number	Expiration Date	CVV Code
Visa			
MasterCard			
Discover			
Amex			

Name as it appears on the card: _____

Authorized Patient/Guardian/Cardholder's Signature: _____

Billing address on file with credit card:

Street Address: _____

City / State / Zip: _____

Date: _____

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Cancellations and No-shows Policy

The following are our policies regarding cancellations and no-shows. We take this subject seriously at the clinic because it can make the difference between whether you succeed in your treatment or not. Usually your referring doctor and/or your therapist have prescribed a set frequency of treatment. Showing up as scheduled for these visits is your most important job. Other than that, all you need to do is follow your therapist's instructions and we will be able to help you achieve your goals in treatment.

Cancellations

- We require a **full 24 hours' notice** in the event of a cancellation. It is your responsibility, when you call in, to have an alternative time in mind, preferably in the same week, that will ensure you get in the full prescribed number of treatments. You must call the office @ (815)838-0529, e-mails are not accepted.
- The first occurrence of either of the following will not incur a charge:
    1. an appointment cancellation without 24 hours' notice
    2. an arrival more than 15 minutes after scheduled appointment time
- All subsequent occurrences of either of the following will result in a $75 charge to your account:
    1. an appointment cancellation without 24 hours' notice
    2. an arrival more than 15 minutes after scheduled appointment time

  This charge will not be covered by insurance but will have to be paid by you personally.

No-shows

- A no-show is a missed appointment without notice and will result in a $150 charge to your account

  This charge will not be covered by insurance but will have to be paid by you personally.

  No-shows will NOT be waived.

When you don't show as scheduled, three people are hurt: You because you don't get the treatment you need as prescribed by the doctor and/or PT; the therapist who now has a space in their schedule since the time was reserved for you personally; and another patient who could have been scheduled for treatment if you had given proper notice.

Thank you for cooperating with us in this regard. We are looking forward to working with you.

_____ _____
Patient/Guardian Signature Date

_____ _____
Interviewer Signature Date

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Financial Policy

Thank you for choosing Kirk Center for Healthy Living as your healthcare provider. We are committed to providing the best possible care, and understand your need to plan for associated costs. With healthcare reform, insurers require patients to share more cost than before. As a result, you may be left with a larger balance due after insurance.

Payment Guarantee: Patients are responsible for payment of all services. We file insurance claims as a courtesy; however, the responsibility is yours. We will be professional and courteous when asking for payment, and ask that you extend the same courtesy to our staff. We have no input on amounts dictated by your insurance.

Insurance: You should verify benefits and know your coverage prior to services, as your policy is a contract between you and your carrier. Coverage levels vary with options purchased. There is no "standard plan," and no particular benefit applies to everyone, even with healthcare reform. If you have no benefit or we are non-participating, you are free to decide whether or not to seek services. A self-pay discount is available.

- We do not recommend making healthcare decisions based solely on benefits, as care may still be needed.
- You should contact your carrier directly with coverage questions/disputes. Not all plans cover routine benefits.
- We are unable to re-code claims to enhance benefits, or write off deductibles, copays or coinsurance.
- We currently do not participate in HMO plans or accept Medicaid patients.

Billing Information: It is essential that you provide complete and accurate billing/insurance information at check-in.

- If you do not present a participating, active card at check-in, full payment is needed – discount available.
- Any delays in providing accurate insurance information may result in claim denial or unexpected portions due.

Assignment of Benefits: For insurance and government coverage, you agree that all medical and related benefits will be irrevocably assigned to our providers on your behalf. **Initial Here:** _____

Release of Information for Insurance Payment: If you are paying with insurance or government coverage, you authorize any holder of your medical or other information to release to the payer information needed for payment.

Initial Here: _____

Payment Arrangements: Payment of balance is due upon receipt of statement. If a payment plan is needed in cases of hardship, we will try to offer a short-term 3-installment plan upon verification to be paid within 3 monthly payments. We may be unable to provide long-term financing of your balance beyond that, as high deductibles and patient cost sharing have now become the norm. As much as we have tried in the past to accept low partial payments, as a small practice we can no longer finance balances. Partial payments need to be approved prior, or you risk collection activity (even if small payments are made). Plans with high unmet deductibles or accounts with unpaid balances may require a deposit.

Consent for Treatment: I/We hereby authorize Kirk Center for Healthy Living to administer diagnostic and medical procedures as may be necessary for proper health care.

Office Policy on Payment: I understand that I am responsible for payment of all charges. As a courtesy, my insurance will be billed for me. It is my responsibility to pay any deductible, co-pay or any other balance not paid for by my insurance company. I authorize insurance benefits to be paid directly to the provider.

In addition to the principle amount owed, I agree to pay 33.33% of the unpaid balance as collection fees if my account is turned over to a collection agency. I understand I will be charged $75.00 for all appointments not cancelled within a 24 hour notice.

_____ _____

Signature Date