PATIENT INFORMATION (This section refers to patient only)

PATIENT NAME _____ DATE OF BIRTH ____/_____/_____ AGE ____
LAST FIRST MI

ADDRESS_____ SS# _____
STREET CITY, STATE ZIP CODE

___ MALE ___ FEMALE (CIRCLE ONE) : MINOR SINGLE MARRIED PARTNERED DIVORCED WIDOWED SEPARATED

ARE YOU CURRENTLY (CIRCLE ONE): EMPLOYED UNEMPLOYED RETIRED DISABLED MILITARY STUDENT

PATIENT EMPLOYER/SCHOOL: _____ OCCUPATION: _____

EMPLOYER ADDRESS: _____
STREET CITY STATE ZIP

EMPLOYER PHONE: ( ) _____-_____ MAY WE CALL YOU AT WORK? YES NO

SPOUSE/PARTNER NAME: _____ SPOUSE/PARTNER BIRTHDATE: _____/_____/_____ SS# _____

SPOUSE/PARTNER EMPLOYER: _____ EMPLOYER PHONE: ( ) _____-_____

PHONE NUMBERS

HOME PHONE: ( ) _____-_____ CELL PHONE: ( ) _____- _____

WHAT IS THE BEST TIME TO REACH YOU? _____ MAY WE LEAVE MESSAGES ON YOUR ANSWERING MACHINE? YES NO

EMAIL ADDRESS: _____ WOULD YOU LIKE TO RECEIVE EMAIL NEWSLETTERS? YES NO

IN CASE OF EMERGENCY, CONTACT:

NAME: _____ RELATIONSHIP: _____

EMERGENCY HOME PHONE: ( ) _____-_____ EMERGENCY WORK PHONE: ( ) _____-_____

PHYSICIAN INFORMATION

REFERRING PHYSICIAN: _____ NEXT PHYSICIAN APPOINTMENT DATE _____

PARENT INFORMATION (If patient is not a minor or student, skip this section)

FATHER'S NAME _____ MOTHER'S NAME _____

ADDRESS (if different from above) _____ ADDRESS (if different from above) _____

_____ _____

HOME ( ) _____ CELL ( ) _____ HOME ( ) _____ CELL ( )_____

EMPLOYER_____ EMPLOYER _____

EMPLOYER PHONE ( ) _____ EMPLOYER PHONE ( ) _____

SS# _____ DOB_____/_____/_____ SS# _____ DOB_____/_____/_____

RESPONSIBLE PARTY

RESPONSIBLE PARTY NAME**:** _____

(CIRCLE ONE): SELF PARENT SPOUSE LEGAL GUARDIAN POWER OF ATTORNEY

OFFICE USE ONLY:

INITIAL APPOINTMENT DATE: _____/_____/_____ THERAPIST CODE: _____ PATIENT #: _____

DIAGNOSIS: _____ CODE(S): _____

PATIENT HEALTH QUESTIONNAIRE

Is this condition due to an accident or injury? Yes No **Date of accident/injury:** _____/_____/_____

Have you recently received Home Health Services? Yes No **If yes, when**_____

Please describe your symptoms:_____

When did your symptoms start? _____

How did your symptoms begin? _____

Are your symptoms (Circle one) Getting Better Getting Worse Not Changing

How are you able to sleep at night? (Circle one) Fine Moderate Difficulty Only with Medication

Affected Side (Circle all that apply) Right Left Both **Hand Dominance:** Right Left Both

Location of your pain:_____

Who have you seen for your symptoms? (Circle all that apply)

No One Medical Doctor Physical Therapist Occupational Therapist Chiropractor Other

What treatment (if any) did you receive and when? _____

What tests have you received for your symptoms? (Circle all that apply)

X-Rays CT Scan MRI Injection Other _____

Did you have surgery for this condition? Yes No **If yes, date of surgery?** _____/_____/_____

Please list your previous surgeries and year: _____

_____

Please list current medications or provide office with a photocopy:

_____

_____

Do you currently smoke tobacco? Yes No **If yes, how many packs per day?** _____

Have you smoked in the past? Yes No **If yes, what year did you quit?** _____

Do you have a pacemaker? Yes No

Have you ever been told that you have any of the following?

Cancer	Yes	No
Diabetes	Yes	No
Autoimmune Deficiency	Yes	No
High Blood Pressure	Yes	No
Heart Disease	Yes	No
Angina/Chest Pain	Yes	No
Stroke	Yes	No
Osteoarthritis	Yes	No
Rheumatoid Arthritis	Yes	No
Hepatitis	Yes	No
Sexually Transmitted Disease	Yes	No

Do you have a history of any of the following?

Allergies/Asthma	Yes	No
Headaches	Yes	No
Seizures	Yes	No
Adhesive Allergy	Yes	No

In the past 3 months have you had or experienced any of the following:

Numbness or Tingling	Yes	No
Weakness or Fatigue	Yes	No
Shortness of Breath	Yes	No
Dizziness	Yes	No
Leg/Ankle Swelling	Yes	No
Unexplained Weight Loss	Yes	No
Changes in Bowel Function	Yes	No
Changes in Bladder Function	Yes	No

Are you currently or could you be pregnant?	Yes	No
Are you currently or could you be depressed?	Yes	No

_____

Patient's Name

PHYSICAL THERAPY & SPORTS REHAB OF HASTINGS (PTSR)
FINANCIAL AGREEMENT

ALL ACCOUNTS FOR SERVICES RENDERED ARE DUE AND PAYABLE AT THE TIME OF SERVICE UNLESS OTHERWISE NOTED IN THE FINANCIAL AGREEMENT FORM. ALL ACCOUNTS WILL BE CONSIDERED DELINQUENT IF NOT PAID WITHIN 30 DAYS FROM NOTIFICATION.

PAYMENT AGREEMENT

PLEASE CHOOSE THE APPROPRIATE COVERAGE(S) AND INITIAL:

HEALTH INSURANCE

_____ **(Initial)** I am covered by a HEALTH INSURANCE plan and I understand all payments on this claim will go directly to PTSR. I agree to pay the amount my insurance plan indicates that I am responsible for at the time of service. I will also handle any discrepancies directly with my insurance company. I understand that not all health coverage plans cover supplies; therefore, I will pay for any supplies at the time it is dispensed.

- *Since coverage is unique to each policy, I am responsible to verify my therapy benefits regarding specific provisions (i.e. need for a physician's referral, pre-authorization, number of allowed visits, co-payment amounts, etc.).*

MEDICARE

_____ **(Initial)** I am a MEDICARE recipient, and understand that PTSR will file my claim to Medicare. I also understand that payment for services will go directly to PTSR. Once my deductible has been met, Medicare will cover my claim at 80% after my deductible has been satisfied. I will then be responsible for the remaining 20% unless I have furnished a secondary insurance. I understand that I may be responsible for any balance due depending upon my secondary insurance coverage. I understand that Medicare does not cover all supplies. If I wish to purchase any supply, I am expected to pay at the time it is dispensed.

MEDICAID

_____ **(Initial)** I am covered by MEDICAID MANAGED CARE and will produce my current Medicaid card each month I am receiving therapy for the purpose of verification of coverage by PTSR. I understand that payment for services will go directly to PTSR. I understand that Medicaid does not cover all types of supplies; therefore, I will be responsible for payment at the time of service. Should my Medicaid plan have a co-pay requirement, I agree to pay my co-pay at the time of service.

WORKERS COMPENSATION

_____ **(Initial)** I have a work related injury and have notified my employer. I understand that all charges remain my responsibility until a Workman's Compensation claim is **validated** by my employer and their agents. Upon authorization, PTSR will bill my employer for the services rendered and payment will be made directly to PTSR. In the event of a dispute or denial with my employer regarding the work injury, I accept full responsibility for payment on my account at the time of service. I understand that I would also have the option to send claims through my health insurance plan upon any denial or dispute.

NO INSURANCE

_____ **(Initial)** I have no insurance coverage, and I will pay at the time services are rendered.

LIABILITY INSURANCE (Med Pay)

_____ **(Initial)** I have been involved in an accident and have verified medical payment coverage through my insurance. I understand that payment for services will go directly to PTSR. I am also aware that I am responsible for payment on my account, at the time services are rendered, once my med pay has been exhausted. At that time, I understand I then have the option to submit claims to my health insurance plan.

LAW SUIT/SETTLEMENT

_____ **(Initial)** Although, I am involved in litigation, I am responsible for payment on my account at the time services are rendered. I understand that PTSR will not wait for payment from any settlement I may or may not receive in the future. I also understand that PTSR will not agree to bill an attorney for services rendered. I also have the option to submit claims to my health insurance plan once they have been notified of the situation.

Would you like to use our credit card payment option? Yes_____ No_____
(VISA, MasterCard, Discover, Debit Accepted)

OVER....

INSURANCE INFORMATION

PRIMARY HEALTH INSURANCE (If Applicable)

*** Photocopy of Card Required**

Name of Insured _____

Relationship to Patient _____

Insured DOB _____/_____/_____ SS# _____

Employer _____

Occupation _____

SECONDARY HEALTH INSURANCE (If Applicable)

*** Photocopy of Card Required**

Name of Insured _____

Relationship to Patient _____

Insured DOB _____/_____/_____ SS# _____

Employer _____

Occupation _____

WORKERS COMP INSURANCE (If Applicable)

Insurance Company_____

Contact Person _____

Insurance Address _____

_____

Insurance Phone # _____

Case Manager _____

Case Manager's Phone #_____

Claim # _____

AUTO/LIABILITY INSURANCE (If Applicable)

Insurance Company_____

Contact Person _____

Insurance Address _____

_____

Insurance Phone # _____

Agent's Name _____

Agent's Phone # _____

Claim # _____

DECLARATION

_____(Initial) The undersigned hereby acknowledges that PTSR may release information from my medical records during the period of such care to the health insurance company, Worker's Compensation insurance, third party payors, other health plans and/or other health practitioners for the purpose of processing claims and to obtain payment on the account for services rendered.

_____(Initial) The undersigned acknowledges responsibility for services not covered by insurance including care that insurance deemed as "*not medically necessary*".

_____(Initial) The undersigned hereby acknowledges that Physical Therapy & Sports Rehab of Hastings has made available to me their *"Notice of Privacy Practices"* for protected health information.

_____(Initial) The undersigned hereby acknowledges that Physical Therapy & Sports Rehab of Hastings will not agree to bill an attorney for services rendered on behalf of the patient.

_____(Initial) The undersigned hereby acknowledges that any returned checks will be subject to a $25.00 fee.

_____(Initial) The undersigned hereby acknowledges that in the event the account is turned over to the collection agency, the collection fees, and/or legal fees, including attorney fees shall be my responsibility.

This agreement is binding upon the patient, his/her successors and assigns. My signature below indicates that I am accepting financial responsibility for all services rendered and certify accuracy of information as noted above. If signed by an individual other than the patient, that individual agrees that he/she will assume full financial responsibility for the patient and understands the Declaration. A copy of this financial agreement may be used in lieu of the original.

MY SIGNATURE BELOW INDICATES THAT I HAVE READ THIS AGREEMENT AND UNDERSTAND IT FULLY. PTSR WILL PROVIDE ME WITH A COPY OF THIS DOCUMENT UPON MY REQUEST.

_____ _____ _____

Signature (*Must be 18 years old to sign*) Relationship to Patient Date

Witness/Date: _____