PATIENT INFORMATION (This section refers to patient only)

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

STREET ADDRESS____ SS# ____________________
STREET CITY, STATE ZIP CODE

BILLING ADDRESS IF DIFFERENT THAN ABOVE (i.e. PO BOX) ______________________________

___ 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: ( ) ______- __________

CIRCLE WHICH IS THE BEST NUMBER TO REACH YOU? HOME CELL

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

**** WOULD YOU LIKE TO RECEIVE AUTOMATED APPOINTMENT REMINDERS? YES (CIRCLE ONE BELOW) NO**

HOME PHONE CELL PHONE EMAIL

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 ____________________
ADDRESS (if different from above) ____________________
____
HOME ( ) __________ CELL ( ) __________
EMPLOYER____________________
EMPLOYER PHONE ( ) ____________________
SS# ____________ DOB____/____/____

MOTHER'S NAME ____________________
ADDRESS (if different from above) ____________________
____
HOME ( ) __________ CELL ( )__________
EMPLOYER ____________________
EMPLOYER PHONE ( ) ____________________
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: ________ INSURANCE: ____________________

PATIENT HEALTH QUESTIONAIRRE

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

If yes, it is related to (Circle One) **Work** **Auto** **Other** ____________________

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

How did your symptoms begin? ____________________

Location of your pain ____________________

Please describe your symptoms (sharp/dull, constant/intermittent)____________________

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

Hand Dominance: Right Left Both

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 <u>injuries</u> and <u>surgeries</u> and the 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?** ____________

Do you have a pacemaker? Yes No **Are you currently or could you be pregnant?** 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

Do you have a history of any of the following?

Allergies/Asthma	Yes	No
Headaches	Yes	No
Seizures	Yes	No
Adhesive Allergy	Yes	No
Depression	Yes	No
Stroke/TIA	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

____

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 THAT YOU HAVE READ AND UNDERSTAND YOUR RESPONSIBILITY:

HEALTH INSURANCE *(COPY OF INSURANCE CARD(S) REQUIRED)*

______ **(Initial)** I am covered by a HEALTH INSURANCE plan(s) 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 *(COPY OF MEDICARE CARD REQUIRED)*

______ **(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 *(COPY OF MEDICAID CARD REQUIRED)*

______ **(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.

OVER....

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: ______________________________