PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Address: _____ City: _____ State: _____ Zip: _____

Birth Date: _____ Age: _____ Sex: M F

Cell: _____ Home Phone: _____ **Email** _____

How do you prefer your appointment reminders? ☐ Text ☐ Voicemail ☐ Email (add email above)

Emergency Contact (Name): _____ (Phone#): _____

Do we have permission to discuss protected health information with your emergency contact? ☐ Yes ☐ No

How did you hear about us? _____

INSURANCE INFORMATION

Primary Insurance: _____

Secondary Insurance: _____ ☐ NA

If this condition is related to a work injury or accident, please provide the following information:

☐ NA

Insurance Carrier: _____ Date of injury or accident: _____

Employer if Work Injury: _____

Patient's Authorized Signature: I hereby authorize release of medical or other information necessary to process the claim. I allow assignment of insurance payments to Therapy Works Physical Therapy for services described on insurance forms. I consent to communication via text and email as noted above and can opt-out at any time.

Signed: _____ Date: _____

I have been given an opportunity to read and understand the Notice of Privacy Practices (HIPAA notice) and I consent to allow Therapy Works Physical Therapy to disclose protected health information for treatment, payment, and health care operations. **I furthermore consent to treatment by the therapists working for and with Therapy Works Physical Therapy.** I understand that with all medical interventions there are risks involved and that no guarantee for outcome may be made.

Signed: _____ Date: _____

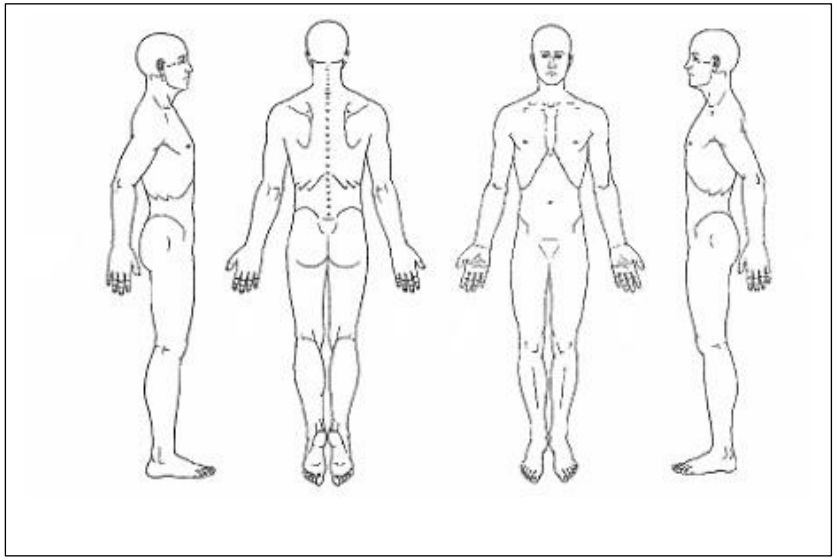
PLEASE FILL OUT FORM COMPLETETLY

Name _____ Date _____

DOB _____ **Height** _____ **Weight** _____

Occupation _____ Military Yes ◯ No◯

Shade in problem areas:



What is your primary complaint? _____

_____

Where did the injury occur? _____

When did the injury occur? _____

What can you **not** do because of injury? _____

_____

_____

Have you seen a medical provider for this condition? Yes ◯ No◯

Primary body part affected? _____

Other symptoms? _____

Have you had any falls in the last 12 months? Yes ◯ No◯ How many? _____

What are your recreational activities and what is your exercise frequency? _____

_____

Please indicate your stress level: (Low) 0----------5----------10 (High)

What do you hope to achieve with physical therapy? _____

_____

_____

Is this a new injury? Yes ◯ No◯ If no, please list previous treatment/testing:

_____

Please list any past injuries, accidents, and/or surgeries and date of occurrence:

_____

_____

Current Medications (Rx & over the counter): _____

_____

_____

Past medical history: ◯ Allergies ◯ Arthritis ◯ Blood disorders ◯ Broken bone
◯ Cancer (type) _____ ◯ Heart problems ◯ Circulation/vascular problems
◯ High blood pressure ◯ Depression ◯ Kidney problems ◯ Lung problems
◯ Epilepsy/seizures ◯ Head injury ◯ Thyroid problems ◯ Osteoporosis
◯ Rheumatoid arthritis ◯ Stroke ◯ Stomach problems
◯ Diabetes (type) _____ ◯ Infection diseases (i.e. hepatitis, TB, etc)

_____

FINANCIAL POLICY

INSURANCE: Prior to your initial visit we will attempt to verify your insurance coverage. Verification of benefits is NOT a guarantee of payment. **It is your responsibility to understand your insurance benefits.** Benefits are based on insurance coverage at the time of service. Our verification of benefits is based on the understanding that you are not being treated by home health, a chiropractor, massage therapist, acupuncturist, or a physical, speech, or occupational therapist outside of our clinics, as treatments by such providers may impact your insurance benefits.

COPAYS, COINSURANCE, AND DEDUCTIBLES: Per our contract with your insurance company, we must collect **copays** directly from you. **Coinsurance** is due at the time of each visit. For example, if your coinsurance is 15%, then $15.00 is due. We will balance bill for anything beyond that after claims are processed**.** Often your annual **deductible** must be met before insurance will pay for physical therapy benefits. If you have an unmet deductible, our policy is to collect $50.00 **towards** that deductible at the time of service. **Please present your payment upon arrival.**

MEDICARE: We accept Medicare, and we will bill Medicare as well as supplemental insurance companies. You are responsible for any copayment, co-insurance or deductible that applies to your plan.

NO INSURANCE/CASH RATE: We offer a cash rate to those who don't have insurance coverage or who have maximized their benefits. We may also accept this self-pay rate of payment if you do not wish to involve your insurance provider. This option does have certain restrictions and our staff can help answer your questions.

MOTOR VEHICLE ACCIDENTS AND WORKERS COMPENSATION: It is your responsibility to provide us with your insurance carrier and your claim number. If your claim is denied for any reason, we will attempt to bill your private health insurance. However, you are ultimately responsible for payment in full. We do NOT accept an attorney letter of protection for claims being disputed or in litigation, but we can bill private insurance which your attorney can add to your case.

Patients with SAIF worker's compensation claim: If you receive a letter stating you have been enrolled with Majoris please notify us immediately. We are not providers for this network and will have to move your care to a participating provider's office.

UNPAID BALANCES: Account balances past due 60 days without making a payment agreement will be assigned to a third party collection specialist. A transfer fee of $25 will be added to your account.

SUPPLIES: Some PT equipment may be available for loan. If not returned by the due date items will be billed to you.

I have read and agree to the Financial Policies of Therapy Works Physical Therapy. I understand I am ultimately responsible for payment of my account with Therapy Works Physical Therapy regardless of my insurance coverage.

24 HOUR CANCELLATION POLICY: Please provide our front office with a 24-hour notice by phone (not email or text) to change or cancel an appointment.
No Shows or cancellations received less than 24 hours prior to your scheduled appointment may result in a cancellation fee of $50.
These charges cannot be billed to your insurance company and will be your responsibility.
If late cancellations or No Shows become an issue, we reserve the right to see you on a Same Day Only Basis to be determined at our discretion.

(Initial/Date)_____

Name: _____ Date: _____