PHYSICAL THERAPY CLINIC OF LAFAYETTE
PATIENT INFORMATION

FORMS MUST BE FILLED OUT IN THEIR ENTIRETY

YOUR NEXT DR APPT:_____ DATE:_____

REFERRING PHYSICIAN_____ SOCIAL SECURITY#_____

PATIENT'S NAME_____ DATE OF BIRTH_____

HOME ADDRESS_____ MALE_____ FEMALE_____ AGE_____

MAILING ADDRESS_____ HOME PHONE_____

CITY, STATE, ZIP_____ EMAIL_____

CELL PHONE_____ MAY WE CONTACT YOU AT WORK?
_____YES _____NO

PATIENT'S EMPLOYER_____ WORK PHONE #_____

EMPLOYERS ADDRESS_____ CITY, STATE, ZIP_____

SPOUSE/PARENT'S NAME_____ EMPLOYER_____
***need parent's info if patient is a minor
SPOUSE'S DATE OF BIRTH_____ EMPLOYER'S PHONE #_____

OTHER RELATIVE NOT LIVING WITH PATIENT
NAME_____ ADDRESS_____
PHONE_____ CELL_____

TYPE OF INJURY: AUTO_____ACTUAL DATE OF ACCIDENT_____
WORK RELATED_____ ACTUAL DATE OF INJURY_____
ARTHRITIS_____ SCHOOL SPORTS_____ OTHER_____
UNKNOWN_____

LOCATION OF PAIN_____ SYMPTOMS_____

HAVE YOU RECEIVED ANY PREVIOUS PHYSICAL, OCCUPATIONAL OR SPEECH THERAPY THIS YEAR?
YES_____ NO_____

ARE YOU PRESENTLY RECEIVING ANY HOME HEALTH SERVICES? YES_____ NO_____
IF YES, WHAT AGENCY IS PROVIDING SERVICES_____

ARE YOU TAKING MEDICATION FOR THIS INJURY_____

SURGERY RELATED TO THIS INJURY_____ DATE OF SURGERY_____

HAVE YOU EVER RECEIVED THERAPY WITH US BEFORE?_____
IF YES, WHAT THERAPIST DID YOU SEE, WHAT WE TREATED AND WHAT YEAR_____

HOW DID YOU HEAR ABOUT US: Dr. REFERRAL_____ FRIEND_____ INTERNET_____ INSURANCE_____

RETURNING PATIENT_____ OTHER_____

FOR OFFICE USE

ACCT#_____ THERAPIST_____ PTPN_____

DIAGNOSIS_____ _____ _____ USER DEF FIELD_____

PERTINENT MEDICAL HISTORY

PATIENT NAME_____DATE_____

PHONE NUMBER YOU CAN BE REACHED AT DURING THE DAY_____

DO YOU HAVE A HISTORY OF:	**YES**	**NO**	**REMARKS**
HIGH BLOOD PRESSURE			
HEART DISEASE/CONDITION			
RESPIRATORY PROBLEMS/ASTHMA			
CANCER			
BROKEN BONES			
SMOKING			
FIBROMYALGIA			
BLOOD THINNER'S			
DIABETIC			
HEPATITIS B/ AIDS			
ANY OTHER MEDICAL CONDITIONS			

DO YOU HAVE:	**YES**	**NO**	**REMARKS**
PACEMAKER/DEFIBRILLATOR			
METAL IMPLANTS			
ARE YOU PREGNANT			

HAVE YOU EVER RECEIVED PHYSICAL, OCCUPATIONAL OR SPEECH THERAPY AT PHYSICAL THERAPY CLINIC OF LAFAYETTE BEFORE? _____

PLEASE LIST ANY SURGERIES YOU HAVE HAD:_____

*** IF YOU HAVE A WRITTEN OR TYPED LIST OF MEDICATIONS, WE WILL COPY IT
IF YOU ARE ON ANY MEDICATION, PLEASE LIST BELOW_____

PATIENT'S SIGNATURE_____

THERAPIST SIGNATURE_____

PRIMARY INSURANCE

NAME_____

ADDRESS_____
CITY_____ ST____ ZIP_____

POLICY HOLDER'S NAME_____

RELATION TO HOLDER_____

GROUP#_____ ID#_____

HOLDER'S SS#_____
HOLDER'S DATE OF BIRTH_____

SECONDARY INSURANCE

NAME_____

ADDRESS_____
CITY_____ST____ ZIP_____

POLICY HOLDER'S NAME_____

RELATION TO HOLDER_____

GROUP#_____ ID#_____

HOLDER'S SS#_____
HOLDER'S DATE OF BIRTH_____

DO YOU HAVE AN ATTORNEY HANDLING THIS INJURY? YES_____ NO_____

ATTORNEY'S NAME_____PHONE #_____

ADDRESS_____CITY, STATE, ZIP_____

WHO WILL BE RESPONSIBLE FOR YOUR BILL?

SELF_____ PERSONAL HEALTH INSURANCE_____ ATTORNEY_____ 3RD PARTY INSURANCE_____

PATIENT SIGNATURE_____
(IF A MINOR, PARENT'S SIGNATURE)

INSURANCE

NAME_____ADDRESS_____

CITY, ST, ZIP_____ PHONE_____
FAX_____

ADJUSTER_____CLAIM#_____

I AUTHORIZE PHYSICAL THERAPY CLINIC OF LAFAYETTE, INC. TO RELEASE INFORMATION TO THE ABOVE MENTIONED INSURANCE COMPANY AND/OR ATTORNEY AND/OR EMPLOYER. WHERE APPLICABLE, I AUTHORIZE DIRECT PAYMENT OF BENEFITS TO PHYSICAL THERAPY CLINIC OF LAFAYETTE, INC FOR SERVICES RENDERED.

SIGNATURE_____DATE_____

Regardless of any prior arrangements, I understand I will be ultimately and fully responsible for payments of all charges incurred on my behalf. Any unpaid balances over 90 days are subject to a finance charge of 1.5% monthly until settlement of account. In the event it becomes necessary to refer my account to an attorney or collection agency, I agree to pay all reasonable late charges, cost and fees associated therewith, whether or not suit is filed.

SIGNATURE_____DATE_____

Physical Therapy Clinic of Lafayette, Inc.
PATIENT INFORMATION CONSENT FORM

I have read and fully understand Physical Therapy Clinic of Lafayette, Inc.'s Notice of Information Practices. I understand that Physical Therapy Clinic of Lafayette, Inc. may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. Physical Therapy Clinic of Lafayette, Inc. may disclose my personal health information to my immediate family members (spouse, parents, and children) or to any athletic personnel (coaches, trainers) as needed in the course of my treatment. I understand that I have the right to restrict how my personal information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Physical Therapy Clinic of Lafayette, Inc. will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for the purposes as noted in Physical Therapy Clinic of Lafayette Inc.'s Notice of Information practices. I understand that I have the right to revoke this consent by notifying the practice in writing at any time.

_____ _____

Patient Name (Print) Parent/ Guardian

_____ _____

Signature Date

DESIGNATED INDIVIDUALS AUTHORIZATION FORM

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ _____

Patient Name (Print) Parent/ Guardian

_____ _____

Signature Date

PHYSICAL THERAPY CLINIC OF LAFAYETTE FINANCIAL POLICY

Dear Client:

Thank you for choosing us for your therapy needs. We are committed to your treatment being successful. The purpose of this policy is to give you information about our billing process and provide you with a clear understanding of your financial responsibility with regard to any and all shared costs. As a courtesy to our insured patients, we will contact your insurance company for benefits, however, this is not a guarantee of payment. The information we receive is only a description of your benefits. Payment is determined by your insurance upon receipt of the claim. Your insurance may contact you for additional information. Please respond to your insurance company's questions as quickly as possible so their processing and payment of the claim is not delayed. We should receive payment from your insurance within 30-45 days after your claim is filed. If there is a difference in the amount paid at time of service, you will receive a statement. Please keep in mind your policy is a contract between you and your insurance company. You are ultimately responsible for you bill.

- The part of the bill that you owe is always required at the time of service. I.E. co-pays, deductibles, or the part your insurance does not pay.
- If you are uninsured, all fees are required at the time of service.
- We accept all major credit cards.
- Our easy-pay program allows us to capture your credit card on file. We will courtesy call you once your insurance has paid. You can authorize the charge or pay by check at that time.

Traditional/HMO/PPO Insurance plans:
We will accept assignment of benefits and courtesy bill your insurance. Insurers are required by state law to pay or deny claims within 45 days. Co-pays are required at the time of service. NO EXCEPTIONS. We accept all major credit cards.

Self-insured employer plan/union plans:
We will accept assignment of benefits and courtesy bill your insurance. We may require EASY-PAY guarantee for billing your employer or union plan.

Workers Compensation:
Patients must have employment information at the time of service. This includes workers comp insurance company, claim number, adjuster's name and phone number for verification of claim. All injuries must have been reported to the employer. If the employer does not carry Worker's Comp insurance, the injured worker is responsible for all charges. Most Workers Comp insurances require pre-authorization or pre-certification. Please allow time for this to be received.

MEDICARE:
We accept assignment with Medicare and will file your secondary and tertiary insurance. You will be responsible for any charges applied to your deductible or co-insurance not paid. For treatment ordered by your physician that are not covered by Medicare, and Advance Beneficiary Notice will need to be signed if you agree to the treatment.

LIABILITY CLAIMS:
All claims will be verified with the insurance company or your attorney. Please have this information available. A lien will be filed for all incurred charges and payment will be due upon settlement of claim. **If you would like us to file a claim with your personal insurance, please inform us of your decision**. **Deductibles, co-pays, co-insurance will be required at the time of service.** Please keep us aware of the status of your claim. You will receive a statement each month until paid in full. **You are ultimately responsible for this bill.**

I acknowledge receipt of this FINANCIAL POLICY_____
NAME **DATE**

WITNESS_____
NAME **DATE**