PATIENT INFORMATION

FORMS MUST BE FILLED OUT IN THEIR ENTIRETY

Referring Physician _____ Next Appt _____

Patient Name: _____ SSN: _____

Home Address: _____ DOB: _____

City, State, Zip: _____ Age: _____

Mailing Address: _____ Gender: O Male O Female

City, State, Zip: _____ Home # _____

Patient Employer: _____ Work # _____

Parent/Spouse: _____ Ok to send text reminders? O Yes O No

Parent/Spouse DOB: _____ Cell # _____

Email Address: _____

Emergency Contact Name: _____ Relationship: _____ Phone: _____

Type of Injury: O Auto O Work Related O Arthritis O School Sports O Other O Unknown

Date of Injury: _____ Location of Pain: _____

Symptoms: _____

Have you received any previous physical, occupational, speech therapy this year? O Yes O No

Are you presently receiving any home health services? O Yes O No ****If yes, please inform the front desk.*****

If yes, which agency? _____

Are you taking any medication for this injury? O Yes O No List it: _____

Surgery related to this injury? O Yes O No Date _____ Type: _____

Have you ever received therapy with us before? O Yes O No

If yes, what therapist did you see, what did we treat, and when? _____

How did you hear about us? O Physician O Friend O Returning Patient O Website/Online O Other_____

Do you have a history of:

High Blood Pressure	O Yes	O No	Heart Disease/Condition	O Yes	O No
Respiratory Problems/Asthma	O Yes	O No	Cancer	O Yes	O No
Broken Bones	O Yes	O No	Smoking	O Yes	O No
Fibromyalgia	O Yes	O No	Blood Thinners	O Yes	O No
Diabetic	O Yes	O No	Hepatitis B/AIDS	O Yes	O No
Pacemaker/Defibrillator	O Yes	O No	Metal Implants	O Yes	O No
Are you right-handed or left?	O Right	O Left	Are you pregnant?	O Yes	O No

Any other medical conditions? _____

List any surgeries: _____

List any medication: _____

List any allergies: _____

Patient Signature: _____ Date: _____

Therapist Signature: _____

Name:		DOB:	

Insurance Information and Patient Consents:

If copy of insurance card(s) was received, check yes and skip to the next section O Yes O No

Primary Insurance:	**Secondary Insurance:**
Address:	Address:
City, State, Zip:	City, State, Zip:
Policy Holder Name:	Policy Holder Name:
Policy Holder DOB:	Policy Holder DOB:
Relation to Holder	Relation to Holder
ID or Subscriber#	ID or Subscriber#
Group #	Group #

Do you have an attorney for this injury? O Yes O No If Yes, attorney name: _____
Address: _____ Phone Number: _____

For any attorney cases, 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.
_____Initial

Was this injury due to an auto accident or is it a work-related injury? O Yes O No

If yes, please fill out the following:
Insurance: _____ Phone: _____
Address: _____ Adjuster _____

PATIENT INFORMATION CONSENT

I have read and fully understand Physical Therapy Clinic of Lafayette, Inc.'s (PTCL) Notice of Information Practices. I understand that PTCL. 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. PTCL 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 PTCL will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I authorize PTCL to release information to the above-mentioned insurance company and/or attorney and/or employer. Where applicable, I authorize direct payment of benefits to PTCL for service rendered.

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.

_____
Signature of Patient or Guardian Date

DESIGNATED INDIVIDUALS AUTHORIZATION

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.

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

Patient Signature: _____ Date: _____

Name:		DOB:	

PHYSICAL THERAPY CLINIC OF LAFAYETTE FINANCIAL POLICY

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.

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 an 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: _____

Signature Date