Physical Therapy
& Wellness Institute

Patient Information

Name: ______________________________SSN #:___________________ Email: ________
Address: ______________________City:_______________ State: ___ Zip: _________
Home Phone(___)___________Wk Phone (____)_____________Cell(___)________________
Please which telephone number you prefer to be reached, if necessary? Home / Work / Cell
Date of Birth: _____ Age: _____ Sex: _____ Marital Status: (circle) S M D W
If a dependent child, is the child a full-time student: (circle) Yes /No
Emergency Contact Person: ______________________ Phone #: (____)__________

Work Information **(Where do you work, what do you do)**
Employer/Business: ____
Address of Employer: ____
Employer contact:(*workers comp*) _________________Employer Phone #(___)______________
Rehab Nurse/ Case Manager:________________________Phone #:________________________

Injury: **(Please Circle One) Workman's Comp/Auto/Sports/Other**
Which insurance should we bill? ____
Date of Accident:____________Mechanism of Injury:________________Injured Body Part:___________

Primary Insurance **(Who is paying? If you have your card, don't fill out, we will copy it)**
Name of **Policy Holder**:________________________Policyholder Birth date: _______________
Relationship to Policyholder: (circle) self spouse dependent child
Insurance Name:___________________Phone #_____________Insurance Address: __________
Policy #/ Claim #: ________________Contact Person: _________________________________
Note: If injury due to a motor vehicle accident, please provide secondary insurance info below.

Secondary Insurance **(Required for Medicare/Work/Auto injuries)**
Name of **Policy Holder**: ________________________Policyholder Birth date: ____________________
Relationship to Policyholder: (circle) self spouse dependent child
Insurance Name: ___________________ Phone #________________Insurance Address: ___________

Referral Sources: **(Referred From Who?)**
Referring Physician's Name: ____________________Address:____________________________
Family Doctor's Name: _________________________Address: ____________________________
Attorneys Name: ________________________________Address: ____________________________
Case Manager: __________________________________Address: ____________________________
Chiropractor/Other: _____________________________Address: ____________________________
Have you received physical therapy during current year? ______ If yes, how many visits? ______
Have you received chiropractic services during the current year? _____ If yes, How many? _____

Pain Rating
Right now *(no pain)* 0 ____________5____________10 *(the worse since it started)*

Pain rating at worst yesterday: ___/10 What makes it worse: ____________What helps the most:________

Falls
Have you fallen in the past 12 months? __________ If yes, how many times? __________
Did you sustain any injury in the fall(s)?____

For Staff Only:
Dx codes: _________, _________, _________
Onset Date: ________________ **Prescription Date:** _______________
(If chronic condition, date of prescription is onset date)
Medicare Fall screening code:____________
(_____) Medicare- Pain Assessed (G8440) , (_____) Medicare Co-developement of Plan (G8437)

Medical History: *Some illnesses and conditions are genetically transferred. It is useful for us to know what condition you have or have had in the past. Please tell us:*

Condition	I Had	When	Family
Osteoarthritis	______	_____	_____
Rheumatoid Arthritis	______	_____	_____
Lumbago	______	_____	_____
Rheumatism	______	_____	_____
Back problems	______	_____	_____
Neck problems	______	_____	_____
Sprain/Strain	______	_____	_____
Headaches	______	_____	_____
Joint Pain	______	*Which Joint*	______________
Parkinson's Disease	______	______	______
Diabetes	______	______	______
Obesity	______	______	______
Depression	______	______	______
Hypertension	______	______	______
Heart Disease	______	______	______
Peripheral Vascular Dis	______	______	______
Reflex Sympathetic Dyst.	______	______	______
Hemiplegia (Right/left)	______	______	______
Cancer;	______	______	______

*(**if yes**),what type of cancer?* ____

*Where was the cancer located?*____

*What type of treatment was given?*____

Do you have a pacemaker? yes / no

*Medications:*____
____

How did you hear about us?

My doctor referred me here _____ Insurance list _____
List provided by my doctor _____ Website: _____
Phone book _____ Friend/Family _____ Their name: ____
Other (explain) _____

My Goals in coming to Physical Therapy are:

To Get rid of my Pain _____ To Improve Sports Performance: _____
To Get Stronger _____ To Improve my Work abilities : _____
To Improve Range of motion ______
To get better with my home activities ______

Thank you for taking the time to fill out this paperwork. We will now do whatever it takes to help you get better and improve performance.

FINANCIAL POLICY

We are committed to providing you with the best care possible. If you have medical insurance, we are anxious and pleased to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment for services is due at the time services are rendered. We accept cash, checks, MasterCard or Visa. All insurance identification cards must be submitted for confirmation on the first visit before treatment begins.

Returned checks or balances older than sixty (60) days may be subject to additional collection fees and interest charges of 1.5% per month. All balances that reach 90 days past due may be sent to a collection agency. Should your account be sent to a collection agency, you will be financially responsible for all collection and legal fees that our office incurs in collecting the balance.

Any balance for past services must be paid in full before being seen in our office in the future.

Insurances

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. **You must realize, however, that your insurance is a contract between you, your employer if so provided and the insurance company. We are not a party to that contract except where we are under contract as preferred providers.**

Since we participate with several insurance companies, you must verify with the Office our status with your plan. We will be happy to help you process your insurance claim for reimbursement from companies with which we participate.

If we do participate with your insurance company, all services performed at our office will be submitted to them unless we have received prior notification of non-covered services. **All co-pays, co-insurance and deductible amounts are the patient's responsibility and will be billed to you by our office.**

Some insurance plans may require referrals for services. It is the patient's responsibility to obtain the referral prior to the time of service. If a referral is NOT presented at the time of service, the patient will be responsible for payment in full for services provided at that time. **All co-pays are due at the time of service.**

If we do not participate with your insurance company, we will not bill your insurance carrier and not accept payment from them as payment in full for services performed. Any balance not covered by the insurance company becomes the responsibility of the patient. We will provide you with an itemized bill so that you may submit the charges to your insurance company for reimbursement.

In auto accident cases, we accept auto insurance payments including your benefits under PIP (Personal Injury Protection). It is your responsibility to provide us with this important information as well as your signature (and your attorney's) on the Authorization and Assignment Form. After you have reached your maximum PIP benefit, you are responsible for any remaining balance. If other insurance may cover the remaining balance, it is your responsibility to provide all necessary cooperation and information to our office that will allow us to pursue reimbursement from that source.

Guarantee of Payment on Motor Vehicle Accident / Personal Injuries

If your motor vehicle or personal injury claim becomes a litigation case, then **I, (patient name)________________________________** agree to name ***The Physical Therapy and Wellness Institute*** **as part of the settlement and pay any outstanding balances in full**. If your case reaches settlement and The Physical Therapy and Wellness Institute does not receive payment we retain the right to send your account to collections for payment in full.

In Worker's Compensation cases, We will send appropriate claim forms for services rendered on your behalf. If and when a claim is denied, we will expect payment from the patient within thirty (30) days of the receipt of denial by the carrier. If you have other insurance options that may cover these costs, we will assist you obtaining reimbursement from this alternate source if we are notified by you within the thirty (30) days following the original denial of coverage.

Please bear in mind that not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as therapy providers, our relationship is with you, not with your insurance company. While the filing of a claim is a courtesy that we extend to our patients, **all charges are strictly your responsibility from the dates services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, it is your responsibility to contact us promptly for assistance in the management of your account.**

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY SET FORTH ABOVE. I AGREE TO THE TERMS OF THE FINANCIAL POLICY. I ALSO UNDERSTAND AND AGREE THAT THE TERMS OF THE FINANCIAL POLICY MAY BE AMENDED BY PTW (Physical Therapy & Wellness Institute) AT ANY TIME WITHOUT PRIOR NOTIFICATION TO THE PATIENT.

________________________________ ____________________

Signature of patient and/or guardian Date

Notice Of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Use and Disclosures: There are a number of situations where we may use or disclose to other persons or entities your confidential medical information. Certain uses and disclosures will require you to sign an Acknowledgement that you received our Notice of Privacy Practices, including treatment, payment and health care operations. Any use or disclosure of your protected health information required for anything other than by law or under emergency circumstances may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

Use and Disclosure without Patient Acknowledgement of this Notice:
We will attempt in good faith to obtain your signed Acknowledgement that you received this notice to use and disclose your confidential medical information for the following purposes:

Treatment: We will use your medical information to make decisions about the provision, coordination or management of your health care, including diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your medical information with another health care provider whom we need to consult with respect to your care.

Payment: We may need to use or disclose information in your medical record to obtain reimbursement from you or your health insurance plan, or another insurer for our services rendered to you. This may also include determinations of eligibility or coverage under the appropriate health plan pre-certification of services or review of services for the purposes of reimbursement. This information may also be used for billing, claims management and collection purposes together with related health care data processing through our system.

Operations: Your medical records may be used in our business planning and development operations, including improvement in our methods of operation, general administrative functions and patient newsletters. We may also use the information in our overall compliance planning, medical review activities, and arranging for legal and auditing functions.

Use and Disclosure Without Acknowledgement or Authorization: There are certain circumstances under which we may use or disclose your medical information without first obtaining your acknowledgement or authorization. Those circumstances generally involve public health and oversight activities, law enforcement activities, judicial and administrative proceedings and in the event of death. Specifically, we are required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases and HIV/AIDS status. We are also required to report instances of suspected or documented abuse, neglect or domestic violence**.** We are required to report to appropriate agencies and law enforcement officials information that you or another person are in immediate threat of danger to your health or safety as a result of violent activity. We must also provide medical record information when ordered by a court of law to do so.

Authorization for use or disclosure: Except as outlined in the above sections, your medical information will not be used or disclosed to any other person or entity without your specific authorization, which may be revoked at any time. In particular, except to the extend disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to the information concerning mental health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases which may be contained in your medical records. We likewise will not disclose your medical record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident or to educational authorities, without your written authorization.

Additional uses and disclosures: We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Individual Rights: You have certain rights with respect to your medical record information as follows: You may request that we restrict the uses and disclosures of your medical records information for treatment, payment and operations or restrictions involving your care or payment related to care. We are not required to agree to the restrictions; however, if we agree, we will comply with it, except with respect to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction. In addition, you have the right to request receipt of confidential communications.

(Rev 3/2005)

Patient Agreement for Services and Release of information

Because services are provided to me by PTW, I agree to the following:

1. **Treatment Authorization:** Since my state of health requires of PTW, of my own free will, I agree to actively participate in these services such as assessment, treatments, personal care, and therapeutic exercises prescribed by my physician, and given by the Physical Therapy staff of PTW. I understand that PTW has specific policies, and that these policies include that services can be stopped at any time by my request, the request of my physician, and/or the decision of PTW. I agree to follow all the terms of these PTW policies.

2. **Non-Discrimination:** PTW and the patient agree that services are given without regard to race, color, sex, age, national origin, or handicap.

3. **Release of Information:** I give PTW my permission to give needed information from my records to any of my insurers and to all other agencies, institutions, or individuals from whom I have received health or social services for the release of information to PTW.

4. **Medicare-Title XVIII of the Social Security Act:** I understand that I need to give information so that PTW can apply for and receive payment under this Medicare Act. By signing this, I certify that information given by me is correct.

5. **Authorization for Phone Contact:** I hereby authorize the staff of the PTW to leave information on my phone answering machine regarding insurance information, confirmation of appointments, and contacts regarding further scheduling. I also authorize PTW to leave the aforementioned information with a family member.

6. **Cancellation of Scheduled Physical Therapy Visits:** Most local Physical Therapy centers charge a $25.00 no-show fee for individuals who do not meet scheduled appointments (no-shows). At the Physical Therapy & Wellness Institute, we fully expect all our respected patients and members to abide by the common courtesy of a phone call is a scheduled visit needs to be changed. Chronic no-shows will be discharged from our program.

7. **Documentation of Good Faith to Obtain Written Acknowledgement:**
   I made **good faith effort to obtain the patient's written acknowledgement** of our Notice of Privacy Practices or protected health information by (check all that apply):

   [ ] Showing the patient the Notice of Privacy Practices posted in our office to read prior to receiving treatment.
   [ ] Asking the patient to sign this acknowledgement form.
   [x] Other (explain in detail) Issued PTW's Privacy Policy

Date: ___________ Signature of PTW Staff member:_______________________

Patient Agreement:
I agree to attend when scheduled.
I agree to be respectful towards other patient's privacy.
I agree to give good effort in my rehabilitation program.
I agree that **it is my responsibility** to know and understand the restrictions and guidelines regarding Physical therapy treatment under my medical insurance plan.
I agree **that I am financially responsible** for the any balances accrued from this treatment should my insurance deny my benefits or release of payment to The Physical Therapy and Wellness Institute.

PTW Agreement:
We agree to have staffing available to attend your needs.
We agree to give you the privacy that you expect.
We agree to provide you with quality Physical Therapy to help you achieve a higher level of performance at your body repair shop.

I am the patient, or the responsible party, signed below. I read and understand this agreement.

Signature:_____________________________________ Date:______________________