



Work Injury Patient Information

Name: _____ Date of Birth: _____ Age: ____ Sex: M / F
Address: _____ City: _____ State: ____ Zip: _____
SSN: _____ Marital Status: S M DW
Home Phone(____) _____ Wk Phone (____) _____ Cell(____) _____
Please which telephone number you prefer to be reached, if necessary? Home / Work / Cell
Emergency Contact Person: _____ Phone #: (____) _____

Work Injury Information

Date Of Injury: _____ What Happened: _____
Employer Name: _____
Address of Employer: _____ Employer Phone (____) _____
Employer contact: _____ Phone #: _____

Work Comp Insurance

Insurance Name/Address/Phone: _____
Claim Number: _____ Injured body Area covered: _____
Adjuster: _____ Phone/Fax: _____/_____

Case Manager: _____ Case Manager Company: _____
Phone/Fax: _____/_____

Secondary Insurance (if applicable)

Name of Policy Holder: _____ Policyholder Birth date: _____
Policy Group #: _____ ID# _____
Relationship to Policyholder: (circle) self spouse dependent child
Insurance Name: _____ Phone # _____ Insurance Address: _____

Referring Doctor Name: _____ Adress: _____ Phone : _____
Family Doctor Name: _____ Address: _____ Phone: _____

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? _____

Attorney

Do you have an attorney? Y/N If yes, who is it? _____ Ph # _____
Firm: _____

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: _____

For Staff Only:

Dx codes: _____, _____, _____, _____
Prescription Date: _____
Name of Doctor on the script: _____
Address of Doc (if new): _____
Onset Date: _____
(If chronic condition, date of prescription is onset date)

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:*

<u>Condition</u>	<u>I Had</u>	<u>When</u>	<u>Family</u>
<i>Osteoarthritis</i>	_____	_____	_____
<i>Rheumatoid Arthritis</i>	_____	_____	_____
<i>Lumbago</i>	_____	_____	_____
<i>Rheumatism</i>	_____	_____	_____
<i>Back problems</i>	_____	_____	_____
<i>Neck problems</i>	_____	_____	_____
<i>Sprain/Strain</i>	_____	_____	_____
<i>Headaches</i>	_____	_____	_____
<i>Joint Pain</i>	_____	<i>Which Joint</i>	_____
<i>Parkinson's Disease</i>	_____	_____	_____
<i>Diabetes</i>	_____	_____	_____
<i>Obesity</i>	_____	_____	_____
<i>Depression</i>	_____	_____	_____
<i>Hypertension</i>	_____	_____	_____
<i>Heart Disease</i>	_____	_____	_____
<i>Peripheral Vascular Dis</i>	_____	_____	_____
<i>Reflex Sympathetic Dyst.</i>	_____	_____	_____
<i>Hemiplegia (Right/left)</i>	_____	_____	_____
<i>Cancer;</i>	_____	_____	_____
<i>(if yes), what type of cancer?</i>	_____		
<i>Where was the cancer located?</i>	_____		
<i>What type of treatment was given?</i>	_____		

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) _____	

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.

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: _____

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