Physical Therapy of Concordia

Patient Information Form

Patient Information

Last Name _____ First Name _____ MI _____ SSN _____

Address _____ Address 2 _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Date of Birth _____ Gender _____ Marital Status _____ Email _____

Emergency Contact

Last Name _____ First Name _____

Relationship _____ Phone _____

Employer

Name _____ Work Phone _____

Address _____ Address 2 _____

City _____ State _____ Zip _____

I authorize release of information requested by my insurance plan for payment.

I understand that I am financially responsible for any balance due.

(You have the right to refuse to sign this acknowledgement if you so choose.)

Witness: _____ Date: _____

Patient Signature: _____ Date: _____

Physical Therapy of Concordia

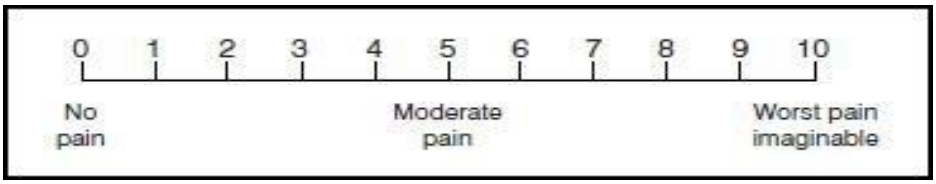
Health & Injury History

NAME: _____

Height_____ Weight_____

Please describe your main problem:_____

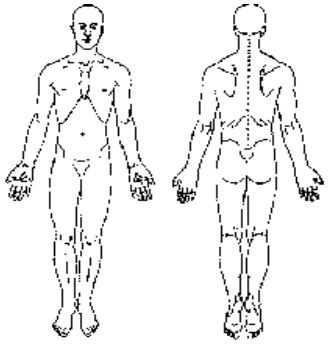
When did it start? _____



Using the diagram above; rate your pain with a number. Present: ____ Best it gets: ____ Worst it gets: ___

Describe your pain (throb, ache, sharp, numbness, tingling) _____

Please indicate on the diagram to the right, where your symptoms are located (circle location)



Is there anything that you can't do right now? (if yes, explain): _____

_____

Do you have a history of falls? (Circle) YES / NO Are your symptoms disrupting your sleep? (Circle) YES / NO

What increases your symptoms: _____ What decreases your symptoms: _____

Are your symptoms disrupting your sleep? _____

Medical History: (please check all boxes that apply to you)

☐Osteoarthriti ☐Cardiovascular Disease ☐Type I Diabetes ☐Type II Diabetes ☐ Psychological issues

☐Vestibular issues ☐Allergies_____ ☐Cancer_____ ☐ High Blood Pressure ☐ Other_____

Surgeries? _____ Smoker? (Circle) YES / NO

List any medication (**including dosage & frequency**) you are currently taking (include prescriptions, over the counter, herbals, vitamins, other)

_____

What treatment/tests have you received? (X-rays, MRI) _____

Marital Status_____ Do you drive? YES / NO Hobbies/ Exercise Frequency? _____

_____

Are you currently working? (Circle) YES / NO Employer? _____

Job Requirements: _____

Prior to injury, any difficulty with activities of daily living? (if yes, explain) _____

_____

List any goals that you want to reach in Physical Therapy: _____

Physical Therapy of Concordia

Privacy Practices

***CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION*:**

USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION
Your protected health information will be used by Physical Therapy of Concordia or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice as described in detail on the previous page.

NOTICE OF PRIVACY PRACTICES
You should review this document for the complete description of how your protected health information may be used or disclosed.

REQUESTING A RESTRICTION ON THE USE OF DISCLOSURE OF YOUR INFORMATION:
You may submit a request in writing as outlined above to restrict your information, however, Physical Therapy of Concordia may or may not agree to restrict the use or disclosure of your protected health information. If Physical Therapy of Concordia agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

REVOCATION OF CONSENT:
You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use of disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

RESERVATION OF RIGHT TO CHANGE PRIVACY PRACTICES:
Physical Therapy of Concordia reserves the right to modify the privacy practices outlined in this notice.

SIGNATURE: I have reviewed this document and give my permission to Physical Therapy of Concordia to use and disclose my health information in accordance with it.

Name of Patient (print, please)

Signature of Patient Date

Signature of Patient Representative Relationship to patient

Physical Therapy of Concordia

PAYMENT POLICY & BILLING PROCEDURES

1. Unless 100% coverage has been verified, you are responsible for the percentage &/or deductible not covered by your insurance company. This payment is requested during each visit.
2. If insurance information is not available or you do not have insurance, payment is due in full unless other arrangements have been approved by our Centralized Billing Office (CBO).
3. You will receive a monthly statement which will show you the status of your account.
4. We accept VISA, MasterCard, and Discover bankcards.
5. There is a $35 charge for all returned checks.

INSURANCE INFORMATION

As a courtesy to our patients, we will verify and file your insurance; however, we cannot guarantee payment. We strongly suggest that you read your policy manual as it pertains to physical therapy coverage. Many Insurance companies have stipulations, such as usual & customary fees (UCR), limited therapy sessions, limited reimbursable amounts per session, deductibles, co-payments, supplies, etc. Such stipulations should be indicated in your policy manual.

YOU ARE RESPONSIBLE FOR AMOUNTS NOT COVERED by your insurance. We have an agreement with YOU, not your insurance company, for receipt of payment. Please be aware of this and plan to make payments accordingly.

Worker's Compensation benefits will be verified; however, this does not guarantee payment. In the event of denial, this account will become YOUR RESPONSIBILITY.

CONSENT TO TREATMENT

I understand that I have been referred for rehabilitative treatment and care to Physical Therapy of Concordia. PT of Concordia has described for me my individual treatment plan. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including any risks or alternatives to the treatment plan that has been prescribed by my physician and/or recommended by my therapist.

The statements are true and complete to the best of my knowledge. I understand, fully, the payment policy & billing procedures of PT of Concordia. I hereby authorize PT of Concordia to furnish my insurance company(s), attorney, or legal representative all information which said parties may request concerning my present illness or injury. I hereby assign PT of Concordia all money to which I am entitled for medical expenses related to the service reported herein, but not to exceed my indebtedness to PT of Concordia. It is understood that any money received from the above named parties over & above my indebtedness will be refunded to me when my bill is paid in full. I understand that I am financially responsible to PT of Concordia for charges not covered by my insurance company. I certify by my signature.

Signature:	Date:
Relationship to Patient (self, parent, guardian, spouse, etc.):	
Witness:	