PHYSICAL THERAPY SPECIALISTS

9757 Westpoint Drive
Suite 200
Indianapolis In 46256
317-845-5400 Phone
317-713-1211 Fax

Patient Information

Patient Name (Full)_____ Date_____

Address_____City_____State ____Zip _____

Home Phone_____Work Phone_____Birth date_____

Sex: M F Marital Status (circle one) Single Married Widowed Divorced Separated

Social Security #_____Occupation_____

Employer_____Employer Address_____

Referring MD _____Date of Return Visit_____

Email _____

FINANCIALLY RESPONSIBLE PERSON

Insured_____ Relationship_____

Address_____City_____State____Zip_____

Home Phone_____Work Phone_____Birth date_____

Employer_____

Employer Address_____City_____State____Zip_____

Other person to notify in emergency_____Phone_____

MEDICAL INSURANCE COVERAGE

Primary Insurance Company_____

ID/Policy #_____Group #/Name_____Subscriber_____

Secondary Insurance Company_____

ID/Policy #_____Group #/Name_____Subscriber_____

Workman's Comp. Insurance Company and Billing Address_____

_____

Employer_____Claim #_____Date of Injury_____

Claims Adjuster_____Phone_____

ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL INFORMATION *(Please read and sign)*

I hereby authorize payment of medical benefits to PHYSICAL THERAPY SPECIALISTS LLC, for services rendered to my dependents or myself. I also authorize the release of any medical information that is necessary to process Medicare and/or insurance claims. I understand that I am responsible for any amount not covered by insurance. I understand that a copy or facsimile of this authorization can be used in place of the original. This assignment will remain in effect until revoked by me in writing.

Patient Signature_____ **Date**_____

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CONDITIONS OF TREATMENT

1. **PATIENT RESPONSIBILITY**: As a patient receiving medical care, you should be aware of your insurance coverage and limitations. Many insurance companies require pre-authorization for physical therapy treatments. It is my responsibility to determine insurance benefits and that Physical Therapy Specialists will assist me in obtaining the necessary pre-authorizations when needed. Failure to obtain necessary pre-authorizations may result in a reduction or rejection of benefits by the insurance company.

2. **ASSIGNMENT OF INSURANCE BENEFITS**: I authorize my insurance company to pay Physical Therapy Specialists, LLC directly. **I understand that I am responsible for charges not covered by my insurance company including late penalty charges.** I agree that a photocopy of this authorization is as effective and valid as the original.

3. **CONFIDENTIALITY**: Confidential information expressly identifies the medical nature of the services rendered to a patient, and includes all information and records obtained during treatment. It includes information from history and physical examination.

4. **MEDICARE AUTHORIZATION: PATIENT'S CERTIFICATION AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST:** I certify that the information given in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about the patient named below to release such information to the Social Security Administration, its intermediaries, or carriers, effective from this date to indefinite.

5. **NO SHOW/CANCELLATION POLICY:** I understand I will be charged a $50.00 fee for no show appointments. This no show fee must be paid prior to being seen at the next appointment.

   I understand any future appointments will be cancelled after 2 no show appointments.

POLICY ON PATIENT ACCOUNTS

1. **PRIMARY INSURANCE**: We will be happy to bill your insurance for you if you provide us with the appropriate billing information. Your insurance will make payment directly to Physical Therapy Specialists and you will be responsible for any deductible, co-payments, or other patient balances. If you have a balance on your account, you will receive a monthly statement until the account is paid in full.

2. **PAYMENT OPTIONS**: Payment options include cash, check, debit cards, HSA cards, and most major credit cards.

3. **SECONDARY/SUPPLEMENTAL INSURANCE**: We bill most secondary/supplemental insurance companies. Please check with the office manager if you wish your secondary/supplemental insurance automatically billed.

4. **BILLS:** All bills are due and payable upon receipt of your monthly statement. If you have special financial needs, please feel free to discuss this with our Office Manager to establish an extension of credit terms.

5. **PAST DUE ACCOUNTS:** Past due accounts will be assigned to an outside agency for collection and reviewed by the Office Manager for further action. You agree that you will pay any accrued interest charges allowed at the current legal rate, all collection fees, returned check fees, attorney fees and court costs incurred by the collection of all sums due.

I have read and understand this financial agreement. I have had an opportunity to ask questions and accept the responsibility of its terms.

_____ _____

Patient/Responsible Party **Date**

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HEALTH HISTORY FORM

Name _____ **Age** _____
Occupation _____

List your chief complaint and health problems that you would like addressed_____
_____

Aggravating Factors □ Sitting □ Walking □ Coughing □ Exercise □ Rest □ Other:_____
_____

Alleviating Factors □ Sitting □ Walking □ Exercise □ Rest □ Other
Explain: _____
_____

Medications (all prescription and non-prescription) _____
_____

Surgeries_____
_____

Imaging, X-rays, MRI, CT (specify by name, dates and results if known)_____
_____

Exercise when injury free (list recent activities, as well as future goals)
_____
_____

Do you have any of the following medical conditions?

Diabetes	□ Yes	□ No
Heart Disease	□ Yes	□ No
Epilepsy	□ Yes	□ No
GI Disorders	□ Yes	□ No
High Blood Pressure	□ Yes	□ No
Bladder Problems	□ Yes	□ No
Bowel Problems	□ Yes	□ No
Hernia	□ Yes	□ No
Asthma	□ Yes	□ No
Pacemaker	□ Yes	□ No
Pregnant (possibility)	□ Yes	□ No
Cancer	□ Yes	□ No

Other medical problems not listed above:

Describe the intensity of your pain: (0 is no pain. 10 is excruciating.) Circle the number that corresponds to your pain.
0-1-2-3-4-5-6-7-8-9-10

_____ _____
Patient/Responsible Party **Date**

Physical Therapy Specialists
Privacy Practice Acknowledgment

By signing below, I hereby acknowledge that I have received a copy of Physical Therapy Specialists' Notice of Privacy Practices, which is HIPAA compliant and per HIPAA guidelines.

_____ _____
Patient Signature Date

_____
Printed Name

I hereby authorize the following person(s) to have access to any Private Health Information on record with Physical Therapy Specialists:

_____ _____
Name Relation

_____ _____
Name Relation

_____ _____
Witnessed by Date