Sam's Physical Therapy, P.C.

148 S Main St, Leslie, MI 49251
Phone: 517.589.9050 Fax: 517.589.9059

GENRAL PATIENT INFORMATION:

PATIENT'S NAME: _____ email: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE#: _____ WORK/CELL#: _____

SEX: _____ AGE: _____ BIRTHDAY: _____ SOC SEC#: _____

EMERGENCY CONTACT: _____ PHONE#: _____

PLACE OF EMPLOYMENT:

EMPLOYER NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

WORK PHONE#: _____ Driver's License#: _____

PHYSICIAN INFORMATION:

REFERRING PHYSICIAN: _____

NPI: _____PHONE: _____FAX: _____

ADDRESS: _____

PRIMARY INSURANCE INFORMATION:

POLICY HOLDERS NAME: _____

POLICY HOLDERS BIRTHDAY: _____ RELATIONSHIP: _____

INSURANCE NAME: _____

CONTRACT / ID#: _____ GROUP #: _____

SECONDARY INSURANCE INFORMATION:

POLICY HOLDERS NAME: _____

POLICY HOLDERS BIRTHDAY: _____ RELATIONSHIP: _____

INSURANCE NAME: _____

CONTRACT / ID#: _____ GROUP #: _____

*****PATIENT SIGNATURE: _____ DATE: _____**

SAM'S PHYSICAL THERAPY, P.C.
Patient Medical History

Patient Name _____ **Age:**_____ **Height:**_____ **Weight:**_____

Medications: _____

CONDITION	YES	NO	DATE	CONDITION	YES	NO	DATE
Asthma	☐	☐	_____	Fracture/Broken Bones	☐	☐	_____
Diabetes	☐	☐	_____	Neuromuscular	☐	☐	_____
High Blood Pressure	☐	☐	_____	Dizziness/Blackouts	☐	☐	_____
Heart Problems	☐	☐	_____	Headache/Migraine	☐	☐	_____
Lung Problems	☐	☐	_____	Blood Clots/Vascular	☐	☐	_____
Cancer	☐	☐	_____	Bladder/Bowel Disorder	☐	☐	_____
Seizures	☐	☐	_____	Pregnancies	#_____		Dates_____
Arthritis	☐	☐	_____	Other_____			
Stroke/CVA	☐	☐	_____				

SURGICAL	YES	NO	DATE	Please Describe
Joint Replacements	☐	☐	_____	_____
Orthopedic Surgery	☐	☐	_____	_____
Heart Surgery	☐	☐	_____	_____
Fracture Reductions	☐	☐	_____	_____
Joint Manipulations	☐	☐	_____	_____
Spinal Surgery	☐	☐	_____	_____

Other Surgeries _____

Please list your current limitations/restrictions

DIAGNOSTICS	YES	NO	DATE	Results
X-Rays	☐	☐	_____	_____
CT Scan	☐	☐	_____	_____
MRI	☐	☐	_____	_____
EMG Nerve Studies	☐	☐	_____	_____
Injections	☐	☐	_____	_____

PAIN/SYMPTOMS

• Please mark your pain on an average day by marking a number on the scale belo

0 _____ **10**

No Pain **ER Visit**

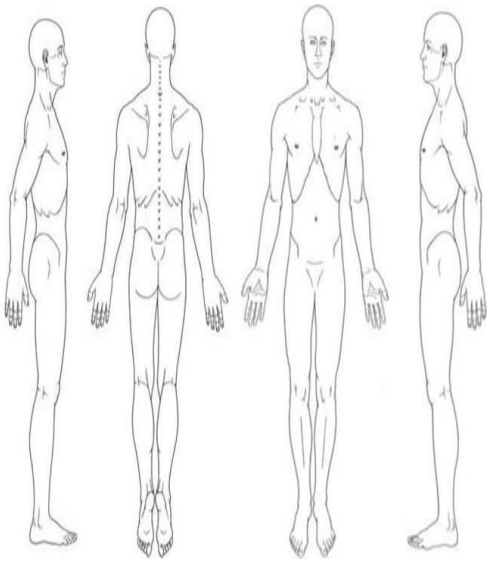
• On the Body Diagram to the right, describe your symptoms using the following sy

(X) Sharp (+) Numb/Tingling (#) Ache (B) Burning

• Have you received PHYSICAL/OCCUPATIONAL THERAPY for this injury bef

If yes, please list date_____

If yes and Medicare patient, please contact billing representative.



Have you had two or more falls in the past year? ☐ Yes ☐ No
Have you had a fall in the past year that resulted in injury? ☐ Yes

Patient Signature _____ **Date** _____

Legal Guardian _____ **Date** _____

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Patient Consent Form

I hereby authorize Sam's Physical Therapy, P.C. and any of their contractors (collectively referred to as Provider) to render patient physical therapy services that provider and patient's physician determine to be necessary. I hereby assign and transfer to provider the right to any and all payments (Medicare, Medicaid and or Private Insurance benefits) that are entitled for therapy services rendered to the patient by the Provider. I also authorize Provider to apply and file for all such benefits for therapy services.

I authorize Provider to disclose or discuss any information related to therapy services to physician, insurance company, family members, and government agency upon request by them. I understand it is my responsibility to know my insurance coverage for therapy. I understand that I will be responsible for any portion of payment that is not paid except for payments denied by Medicare or any other Insurance carrier secondary to non medical reasons.

I hereby certify that all information provided to the Provider is true and accurate.
I understand that under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information.

I understand that this information can and will be used to:
1. Conduct, plan and direct treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third party payers.
3. Conduct normal healthcare operations such as quality assessments and physician's certifications.

I have received, read and understood your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its notice of Privacy Practices from time to time and that I may request the same if needed by writing to the address above.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, and payment of healthcare options.

Patient Signature or Legal Representative: _____ DATE: _____

IT'S A STATE LAW!

As a healthcare provider, we are advised to collect the co-payments and deductibles for each P.T. visit as per your insurance plan and coverage. By not doing this, Sam's Physical Therapy, P.C. will be penalized for going against insurance regulations. Most of the time, we may not know until we bill your insurance about deductibles and the amounts for co-payments. So, we want to make sure that you are aware that you may get a bill from us depending on your insurance plan for P.T. coverage. We request your fullest co-operation regarding this issue. If you have any questions, please contact your insurance company and clarify regarding this.

Patient Signature or Legal Representative: _____ DATE: _____

How would you like to be contacted regarding appointments, treatment and/or other information pertinent to your healthcare and/or payment for our health care provided at Sam's Physical Therapy, P.C.? (Circle all that apply) HOME #: _____ CELL #: _____ WORK #: _____
FRIEND OR FAMILY MEMBER: _____ E-MAIL: _____

___ I FULLY UNDERSTAND AND **ACCEPT** THE TERMS OF THIS CONSENT.

Patient Signature or Legal Representative: _____ DATE: _____

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Financial Policy and Patient Responsibility

Sam's Physical Therapy, P.C. is committed to providing our patients with the highest quality care. We thank you for taking the time and to read and understand our policy.

It is the Patient's Responsibility:

- To know their insurance policy. Patients should be aware of their benefit coverage including which health care providers are contracted with their plan, covered and non-covered benefits, authorization requirements, and cost share information such as deductibles, coinsurance, and co-payments. If you are not familiar with your plan coverage, we recommend you contact your carrier directly.
- To obtain a referral from their Physician and / or obtain authorization for treatment from their insurance carrier **prior to receiving services.** Any non-covered services are the financial responsibility of the patient.
- To pay their co – payment **at the time of service**.
- **AS OF 07/23/12 SAM'S PHYSICAL THERAPY, P.C. WILL NO LONGER CARRY A BALANCE OVER $50.00(FIFTY). THE BALANCE AMOUNT MUST TO BE PAID IN FULL BY 90 DAYS (NINETY) UPON RECIEPT OF INVOICE.**
- Patient may opt to carry a balance over 90 days and need to pay a financial fee of 5% PA on the balance amount. This cannot be waived unless there is a written financial agreement between Sam's Physical Therapy, P.C. and the patient or legal guardian.
- **Failure to pay, patient or legal guardian will be responsible for the entire balance including the cost it takes to collect the money using an outside agency and all applicable court fees.**
- To pay any Medicare deductible and co-insurance amounts not covered by supplemental insurance.
- To promptly pay any patient responsibility indicated by their insurance carrier.
- To facilitate in claims payment by contacting their insurance carrier when claims have not been paid.
- To notify our office at least **24 hours** in advance should you need to cancel your appointment, should you fail to do so or fail to appear for your scheduled appointment you may be charged a **$30 (Thirty) fee. This fee is not billable to your insurance company and is the sole responsibility of the patient**.

Acknowledgement:

I have read and understand the above financial policy and patient responsibility. I understand that, regardless of my insurance claim status or absence of insurance coverage, I am ultimately responsible for the balance on my account for any services rendered.

_____ ____/___/___

Patient or Responsible Party Signature **Date**

CONSENT TO USE OF RECORDS

I hereby give my permission for the use of my physical therapy records, including photographs, made in the process of examinations, treatment, and retention for purpose of professional consultation, education, research, or publication in journals and any form of media.

_____ ____/___/___

Patient or Responsible Party Signature **Date**

_____ ____/___/___

Witness **Date**

I have the legal authority to sign this on behalf of

_____

Name of Patient

_____

Relationship to Patient