



Physical Therapy Plus

Patient Information

Personal Information

Date: _____

Patient's Full Name: _____

Address: _____ Home Phone #: _____

City: _____ State: _____ Zip: _____ Cell Phone #: _____

Date of Birth: _____ Sex: Male Female SSN# _____

E-Mail Address: _____

Marital Status: Single Married Widowed Divorced Separated Minor

Place of Employment: _____ Work #: _____

Employer's Address: _____
Street City State Zip

Emergency Contact Information

Name: _____ Phone # _____

Relationship: _____ Alt. Phone #: _____

How did you hear about us? _____

Medicare YES NO

Are you currently on Home Health Care? YES NO

→ Please see insurance information on back...

Insurance Information

****If you are primary insurance holder you can skip this section... If someone else in your family is primary insurance holder please fill out this information

Primary Insurance

Policy Holder Name: _____ DOB: _____

Policy Holder SSN #: _____ Relationship: _____

Policy Holder's Employer: _____ Phone # _____

Has your deductible been met? YES NO If so, How much? _____

Secondary Insurance

Policy Holder Name: _____ DOB: _____

Policy Holder SSN #: _____ Relationship: _____

Policy Holder's Employer: _____ Phone # _____

Has your deductible been met? YES NO If so, How much? _____

Workers Comp. or Attorney Case

Name of Insurance: _____ Claim# _____

Adjuster Name: _____ Phone # _____

Attorney Name: _____ Phone # _____

Physical Therapy Plus
Medical History

Date: _____

Patient Name: _____

Is this injury a result of a motor vehicle accident? YES NO Date of Injury: _____

Did this injury occur while at work? YES NO Date of Injury: _____

Have you had surgery for the condition that you are being treated? YES NO

Date of Surgery: _____

Work Status: Working Not Working Working w/ restrictions

Medical History

High Blood Pressure YES NO

Heart Disease YES NO

Diabetes YES NO

Respiratory Problems YES NO

Cancer YES NO

Broken Bones YES NO

Stroke YES NO

Other: _____

Do you have...

A Pacemaker? YES NO

Metal Implants? YES NO

Are you Pregnant? YES NO

Comments: _____

Exercise Habits None Moderate Daily Heavy

Please list any surgeries you have had. _____

Please List any medications you are currently taking including frequency & dosage

(can continue list on back if needed or separate page can be attached)

Patient Signature

Therapist Signature

Physical Therapy Plus of Vermilion, Inc.

Patient Information Acknowledgement Form

I have read and fully understand **Physical Therapy Plus of Vermilion, Inc.** Notice of Information Practices. I understand that **Physical Therapy Plus of Vermilion, Inc.** may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that **Physical Therapy Plus of Vermilion, Inc.** will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in **Physical Therapy Plus of Vermilion, Inc.'s** Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at my time.

Patient Name

Signature

Date

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____

DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date

Name

Reason

→ Please see back side...

Physical Therapy Plus of Vermilion, Inc.
Treatment Authorization & Financial Agreement

Thank you for choosing us as your health care provider. The following is a statement of our financial policy, which will require you to read and sign prior to treatment.

I agree to pay **Physical Therapy Plus of Vermilion** for professional services rendered or to be rendered at the time the service is performed unless other arrangements have been made in advance.

I also understand that insurance benefits assigned to **Physical Therapy Plus of Vermilion** must be paid within 60 days from the date of insurance billing. If the insurance company has not paid within 60 days, I agree to pay **Physical Therapy Plus of Vermilion** the full balance within the credit limits of the office. Any payment received by **Physical Therapy Plus of Vermilion** after my balance is paid will be refunded to me. I understand that **Physical Therapy Plus of Vermilion** cannot be responsible for collecting my insurance claim or negotiating a settlement on a disputed claim. I understand that I am ultimately responsible for this account no matter what my insurance company may or may not pay.

Your insurance policy is a contract between you and your insurance company. We are not a party to the contract. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under all contractive care and/or other medical information. Should a problem arise, we will work with you to assist in any way possible. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

I agree to give at least a 24 hour notice if I need to change my appointment. I agree to pay for the appointment time lost if I fail to keep my appointment without giving notice.

I understand that it is necessary for **Physical Therapy Plus of Vermilion** to retain the services of an attorney to collect my unpaid balance. I will be responsible for all court costs, attorney's fees and any other collection fees which may be incurred as a result of my account being turned over for collection as allowed by the State of Louisiana.

Authorization for Release of Medical Information and Treatment

Authorization is hereby given to release medical information and/or copies of medical records from my doctor for any and all of my related previous medical condition to **Physical Therapy Plus of Vermilion**. **Physical Therapy Plus of Vermilion** may provide written and/or verbal reports to my insurance company, worker's compensation company and/or my attorney's.

I agree to pay a fee of \$25.00 for any check returned N.S.F.

I hereby authorize and consent **Physical Therapy Plus of Vermilion** to provide treatment prescribed by my physician related to my rehabilitation.

I have read and understand the above:

Who is financially responsible for this bill? _____

By signing below I am authorizing Physical Therapy Plus to bill the above mentioned financially responsible party. I understand that I am ultimately responsible for this account no matter what the above mentioned party may or may not pay.

Print Name

Social Security Number

Signature of Patient/ Responsible Party

Date

Signature of Co-Responsible Party

Date