

Patient’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance: Attorney/Payment (per visit): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **DATE** | **SIGNATURE** |  | **DATE** | **SIGNATURE** |  | **DATE** | **SIGNATURE** |
| 1 |  |  | 15 |  |  | 29 |  |  |
| 2 |  |  | 16 |  |  | 30 |  |  |
| 3 |  |  | 17 |  |  | 31 |  |  |
| 4 |  |  | 18 |  |  | 32 |  |  |
| 5 |  |  | 19 |  |  | 33 |  |  |
| 6 |  |  | 20 |  |  | 34 |  |  |
| 7 |  |  | 21 |  |  | 35 |  |  |
| 8 |  |  | 22 |  |  | 36 |  |  |
| 9 |  |  | 23 |  |  | 37 |  |  |
| 10 |  |  | 24 |  |  | 38 |  |  |
| 11 |  |  | 25 |  |  | 39 |  |  |
| 12 |  |  | 26 |  |  | 40 |  |  |
| 13 |  |  | 27 |  |  | 41 |  |  |
| 14 |  |  | 28 |  |  | 42 |  |  |

**PATIENT INFORMATION**

Name Last:

First:

M.I.:

SSN:

Address:

City:

State:

Zip:

Home Phone:

Cell Phone:

Email:

Preferred Method of Appt Reminders: [ ] Home Phone [ ] Cell Phone [ ] Text [ ] Email [ ] Check Here For No Appt Reminder

How Did You Hear About Us: [ ] Doctor [ ] Attorney [ ] Hospital [ ] Friend [ ] TV [ ] Radio [ ] Internet [ ] Insurance

Date of Birth:

Gender:

Date of Injury:

Place (State) of Injury:

Emergency Contact:

Relationship:

Phone:

( )

**PATIENT INSURANCE INFORMATION - PLEASE BRING YOUR INSURANCE CARD**

**Primary Insurance Company:**

ID #:

Name of Subscriber:

Date of Birth:

Group #:

Relationship to Subscriber: (Circle One) Self / Spouse / Minor / Other

Employer:

Work Phone:

**Secondary Insurance Company (If Applicable):**

ID #:

Name of Subscriber:

Date of Birth:

Group #:

Relationship to Subscriber: (Circle One) Self / Spouse / Minor / Other

Employer:

Work Phone:

Name Last:

First:

M.I.:

SSN:

Address:

City:

State:

Zip:

Relationship to Subscriber: (Circle One) Self / Spouse / Other

Date of Birth:

Employer:

Work Phone:

**GUARDIAN INFORMATION (IF UNDER 18 YEARS OLD)**

**CONSENT FOR TREATMENT**

**Consent for Treatment:** I understand I have the right to choose my physical therapy provider and have chosen Physical Therapy Now and hereby authorize and give my consent for PT Now to furnish physical therapy care and treatment deemed necessary or advisable in evaluating or treating my physical condition. I further understand no guarantees have been made to me as to the outcome of treatment.

**Consent for Treatment of a Minor:** As parent and/or legal guardian, I authorize and give my consent for Physical Therapy Now

to treat \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (minor's name) while I am not present.

**Patient / Guardian / Responsible Party Signature:**

**Date:**

**Physical Therapy Now  
REGISTRATION FORM**

**Patient Signature:**

**Date:**

**Parent / Guardian / Guarantor:**

**Date:**

**PATIENT AUTHORIZATION**

- By my initials and signature, I understand these policies and my financial obligations for services rendered.

- I hereby assign payment of benefits by my insurance company to Physical Therapy Now, and I accept responsibility to ensure my insurance carrier makes payment on my account within 90 days. Lack of payment by my insurance carrier will result in all charges being transferred to my personal balance on my statement.

- I hereby agree to pay any office visit/co-payment charges at time of visit.

- I hereby agree to promptly pay my personal account balance including co-insurance or unmet deductible upon receipt of my statement. I understand and agree that responsibility for payment for services rendered is mine, due and payable unless other financial arrangements have been made. In the event of default, I agree to pay such collection costs and reasonable attorney fees as may be required to effectively collect the debt.

**OFFICE POLICY AND FINANCIAL RESPONSIBILITY**

**PATIENT INFORMATION CONSENT:** I have read and fully understand Physical Therapy Now's Notice of Information Practices. I understand that PT Now 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 by notifying the practice. I also understand that Physical Therapy Now 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 Now's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

**Initials**

**Initials**

**ATTENDANCE, CANCELLATION, and NO SHOW:** Attendance at your therapy visits is your most important responsibility because it can make the difference between whether or not you succeed in your treatment. While we understand you may need to cancel an appointment because of unforeseen circumstances, we do require at least 24 hour’s notice of cancellation. There is a $25 charge for cancellation without prior notice or for not showing for your appointment. This charge is not covered by insurance, and you are required to pay this fee personally.

**FINANCIAL RESPONSIBILITY:** As a courtesy to you, Physical Therapy Now will file your medical insurance claims. The contract between you as a patient and your insurance company is, however, personal to you. PT Now is not responsible for issues between the patient and insurance carrier, nor can PT Now intervene or negotiate for either party on disputed claims. Please advise us immediately if you change insurance coverage while undergoing treatment. Physical therapy equipment and/or supplies are typically not reimbursable by the insurance carrier. As such, PT Now requires payment by the patient for any equipment/supply at the time the order is placed. HOT will provide a receipt as documentation of the purchase so you may pursue reimbursement personally. PT Now accepts cash, visa, MasterCard, or discover as payment options.

**Initials**

**CONSENT TO CONFIDENTIAL MEDICAL INFORMATION**

I hereby authorize PT Now to share any and all of my medical / billing information with the following people:

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physical Therapy Now

**HIPAA Privacy Role Patient Consent and Acknowledgment**

I consent to the use or disclosure of my protected health information by Physical Therapy NOW LLC; for the purpose of providing me with health care treatment, getting paid for those services and conducting the health care operation portion of its business. I also acknowledge that I received and read the Physical Therapy NOW LLC Notice of Privacy Practices.

I understand the following:

* “My protected health information” means my health-related information either collected from me or received by Physical Therapy NOW LLC, from any other source, and it includes information about my past, present and future physical or mental health.
* If I refuse to sign this consent and acknowledgement, Physical Therapy NOW LLC has the right to refuse me as the patient.
* I have the right to ask Physical Therapy NOW LLC in writing, to limit the way in which it uses or discloses my protected health information, but Physical Therapy NOW LLC does not have to agree to my request. However, if Physical Therapy NOW LLC does agree, then it is bound by that agreement.

I have the right to revoke the Consent portion of this document at any time by providing

* Physical Therapy NOW LLC with a written request specifically stating my desire to revoke my consent to use of the PHI. Physical Therapy NOW LLC must accept this revocation but then may refuse to provide me with further heath care treatment.
* If I revoke the Consent portion of this document, it is effective, except the extent that Physical Therapy NOW LLC, has already used or disclosed my protested health information in reliance on this consent.

Before I signed this Consent and Acknowledgement, I reviewed Physical Therapy NOW LLC, Notice of Privacy Practices, and understand the following with respect to the Notice:

* Physical Therapy NOW LLC has the right to change the terms of the Notice at any time but if it does, it must post the new Notice in the waiting room and give me a copy if I request one.
* The Notice describes in detail, the types of uses and disclosures of my protected health information that Physical Therapy NOW LLC may make in treating me, getting paid for that treatment or in carrying out its health care operations.

I have read and understand this information and have received a copy of this Consent and Acknowledgement. I am the patient, or I am authorized to act on behalf of the patient for the reason described below.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_\_\_\_

Patient or Personal Representative Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Signatory

**Physical Therapy Now Financial Policy**

**Patient:**

**ID #:**

**Primary Insurance:**

We have verified your insurance coverage and benefits as of . This information is being provided to you exactly as it was told to us. Please INITIAL Highlighted Benefits Related to Your Policy.

You have a co-pay associated with your primary insurance.

Yes or No If Yes how much $\_\_\_\_\_\_\_\_\_\_

You do not have a deductible associated with your primary insurance.

Yes or No If Yes how much $\_\_\_\_\_\_\_\_\_\_

You do not have a coinsurance associated with your primary insurance.

Yes or No If Yes how much $\_\_\_\_\_\_\_\_\_\_

You do not have a secondary insurance.

Yes or No If Yes name of secondary insurance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

We accept Cash, Personal Checks, and Credit Cards (MASTERCARD, VISA, AND DISCOVER).

If there are concerns regarding your financial responsibility for this service, please ask the Front Office to speak with our Billing Department or contact them directly at 305-244-5883 to discuss your situation if needed.

Please be aware that your benefits and/or coverage information may be subject to errors. Therefore, we strongly recommend you contact your insurance directly if you have any questions or concerns regarding this benefit.

**CONSENT: I understand these benefits as explained to me.**

**Patient**

**Signature:**

**PT Now Employee   
 Signature:**

**Date:**

**Date:**











\_\_\_\_\_\_\_\_\_\_

**REHABILITATION MEDICAL HISTORY QUESTIONARY**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_ / \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_

D.O.B: \_\_\_\_\_\_ / \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_

Serious illness/Surgery/Hospitalization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were you evaluated by Fire Rescue? (Circle one) YES or NO

Were you transported to hospital? (Circle one) YES or NO If yes which hospital? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Medical & Health Problem: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you feel limited in what you are able to do due to your present condition? If yes, How? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you feel sad, rejected, or depressed about your current conditions? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had problem, in the present or past, with any of the following conditions?

Yes\_\_\_ No \_\_\_ Diabetes

Yes \_\_\_ No \_\_\_ Hypertension

Yes \_\_\_ No \_\_\_ Low Blood Pressure

Yes \_\_\_ No\_\_\_ Sad/Depressed with your Physical problem.

Yes \_\_\_ No\_\_\_ Heart Conditions (Arrhythmias, Murmur, Stent, CAD)

Yes \_\_\_ No \_\_\_ Pacemaker

Yes \_\_\_ No \_\_\_ Circulatory Deficit

Yes \_\_\_ No \_\_\_ Anxiety/ Nervousness

Yes \_\_\_ No \_\_\_ Allergies

Yes \_\_\_ No \_\_\_ Cancer History (self)

Yes \_\_\_ No \_\_\_ Drug/ Alcohol Abuse

Yes \_\_\_ No \_\_\_ Self Isolation

Yes \_\_\_ No \_\_\_ Loss of appetite

Yes \_\_\_ No \_\_\_ Worry about present health

Yes \_\_\_ No \_\_\_ Self-care Difficult

Yes \_\_\_ No \_\_\_ Liver disease

Yes \_\_\_ No \_\_\_ Kidney disease

Yes \_\_\_ No \_\_\_ Immune System

Yes \_\_\_ No \_\_\_ Anxiety over potential for recuperation

Yes \_\_\_ No \_\_\_ Lung/ Breathing difficult/ SOB

Yes \_\_\_ No \_\_\_ Seizures

Yes \_\_\_ No \_\_\_ Stroke

Yes \_\_\_ No \_\_\_ GI/ Gastrointestinal / Diverticulitis

Yes \_\_\_ No \_\_\_ Urinary / Prostate

Yes \_\_\_ No \_\_\_ Anemia

Yes \_\_\_ No \_\_\_ Arthritis / Osteoporosis / Osteopenia

Yes \_\_\_ No \_\_\_Insomnia

Yes \_\_\_ No \_\_\_ Weight loss/ gain

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ / \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_

Patient’s Signature Date