PATIENT INFORMATION

PATIENT NAME				APPT DATE	
MAILING ADDRESS		CITY		STATE	ZIP
HOME PHONE	CELL PHONE	EMAIL			
DATE OF BIRTH	SSN	GENDER		MARITAL STATUS: ☐ M ☐ S ☐ D	
EMERGENCY CONTACT		PHONE NUMBER		RELATIONSHIP	

EMPLOYER INFORMATION

EMPLOYER NAME		EMPLOYMENT STATUS: STUDENT FT PT SELF-EMPLOYED RETIRED		
EMPLOYER ADDRESS			STATE	ZIP
WORK NUMBER	OCCUPATION			

INSURANCE POLICY HOLDER / GUARANTOR INFORMATION

NAME		CONTACT NUMBER	GENDER	
ADDRESS			STATE	ZIP
DATE OF BIRTH	SSN	RELATIONSHIP TO PATIENT		
EMPLOYER NAME		EMPLOYER PHONE NUMBER		

Have you ever received chiropractic care or physical therapy in the current year at another provider or clinic? **YES** OR **NO** (circle one)

If you have, please let us know how many visits you have received so that we may calculate your benefits correctly.

PATIENT SIGNATURE _______________ DATE _______________

CONSENT FOR TREATMENT
RELEASE OF INFORMATION
HIPAA PRIVACY NOTICE
FINANCIAL AGREEMENT

______________________________________ ______________________________
PATIENT NAME **DATE**

CONSENT: I do hereby agree and give my consent for **Palatka Physical Therapy** to furnish therapy treatment.________________
Please initial

Palatka Physical Therapy has my permission to allow students to **OBSERVE** my treatment and care. **YES** ☐ **NO** ☐

RELEASE OF INFORMATION: I agree that **Palatka Physical Therapy** may disclose my "protected health information" (PHI) in compliance with HIPAA Privacy Provisions which may include my medical records, to any third-party payers, including, but not limited to, health care service plans, state and federal agencies, worker's compensation carriers. This includes appropriate release and disclosure of my medical records in compliance with Privacy Provisions to my physicians and other health care providers when necessary for my treatment and general health. While I am in the facility for treatment and care, the facility has permission to disclose pertinent information to family members, friends, or designated caregivers who may be present with me. I understand that if I am not present in the facility, my personal health information will not be disclosed unless I agree to disclosure.

PLEASE LIST BELOW ANY OTHER PEOPLE WITH WHOM YOU AUTHORIZE OUR OFFICE TO DISCUSS YOUR PHI AND/OR BILLING INFORMATION:

Name:_______________________________________ Relationship:_____________________ PHI ☐ BILLING ☐

Name:_______________________________________ Relationship:_____________________ PHI ☐ BILLING ☐

HIPAA PRIVACY NOTICE: I acknowledge that I have received the HIPAA Privacy Notice and have had the opportunity to review its content. ________(Please initial)

FINANCIAL POLICY STATEMENT: As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for the payment of your bill.

You are responsible for payment of an co-payments at the time of service. If your insurance carrier does not remit payment within 60 days, the balance will be due in full, from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. If any payments are made directly to you for services billed by us, you recognize an obligation to promptly remit same to **Palatka Physical Therapy**.

The above does not apply for those patients that are considered Workers' Compensation. However, be advised if you claim WC benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

Note: Estimated coverage information is provided as a courtesy to our patients, but it is not intended to release them from total responsibility for their account balance.

*******ARE YOU BEING TREATED AS A RESULT OF AN AUTO ACCIDENT?***** YES** ☐ **NO** ☐

*******ARE YOU BEING TREATED AS A RESULT OF A WORKERS' COMP ACCIDENT?***** YES** ☐ **NO** ☐

*******ARE YOU BEING TREATED AS A RESULT OF AN ACCIDENT OF ANY KIND?***** YES** ☐ **NO** ☐

I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

______________________________________ ______________________________
PATIENT/GUARDIAN/RESPONSIBLE PARTY **DATE**

______________________________________ ______________________________
EMPLOYEE **DATE**

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PLEASE PRINT ALL INFORMATION EXCEPT FOR REQURIED SIGNATURES

PATIENT NAME:		DATE OF BIRTH:
PATIENT ADDRESS:		
CITY	STATE	ZIP
PHONE #	ALTERNATE PHONE #	

DISCLOSURE OF PROTECTED HEALTH INFORMATION IS MADE AT MY REQUEST FOR: (CIRCLE ONE)

CHANGE OF INSURANCE   REFERRAL   CHANGE OF PHYSICIAN   PHI   OTHER ______________.

RECORDS TO BE DISCLOSED: DESCRIBE WHAT SPECIFIC RECORDS MAY BE DISCLOSED (CIRCLE ALL THAT APPLY)

ALL RECORDS   RECORDS FROM (DATE) ______________.   TO (DATE) ________________.

EVALUATION/PROGRESS NOTES   DISCHARGE SUMMARY   BILLING RECORDS   PHYSICIAN'S SCRIPT

All records means all protected health information in a designated record set, which may include, but is not limited to, patient family histories, genetic information, inpatient/outpatient records, medical, dental, pharmaceuticals (medications), hospital, physician or other healthcare providers' records, office notes, narrative summaries, correspondence to/from/about me, diagnostic testing results, bills, statements @ invoices for services and information from all other health care providers used for your care and treatment in the hospital or facility. If you received a psychiatric or psychotherapy services, alcohol/chemical substance abuse treatment or treatment for HIV/AIDS which are federally protected as confidential, those records will be included unless you specifically exclude them in writing prior to disclosure.

Persons, facility, or class of persons who are authorized to disclose (provide) the records/information:
The facility/hospital named above
Other ___________________________________
Persons, facility, or class of persons who are authorized to receive the records/information:
Physician/hospital/other healthcare provide name ____
Attorney/Law Firm ____
Address ____
City/State/Zip ____
Phone # ____
Please complete more than one form if multiple disclosures to multiple providers are requested.

I authorize the disclosure of the information described. I understand that if the person or entity that receives the described records/information is not a health care provider or health plan covered by federal privacy regulations, the records/information may be redisclosed and no longer protected by those regulations. I also understand that certain records may be protected by federal or state law and I am requesting that any and all such protected records be release under this authorization. If I revoke this authorization, it will have no effect on actions taken or information already sent as authorized by this form. I also understand that the hospital/facility will not condition treatment, payment, enrollment, or eligibility on whether I sign the authorization. I also understand that I may have a copy of this form after I sign it. I also permit disclosure of information upon presentation of a use of a photocopy of this authorization. I understand that I have the right to revoke this authorization. I may do so by delivering or mailing a written revocation to this facility/hospital, any other healthcare provider or attorney or law firm if named above. Unless otherwise revoked, the authorization will expire on the following date, event, or condition ______________________________. If I fail to specify and expiration date, event, or condition, this authorization will expire 1 (one) year from the date signed.
I have read and understand this form. I am the patient listed or am authorized to act on behalf of the patient as the patient's personal representative.

____   ___________________________________
Signature of Patient or Patient Representative   Date
Personal Representative's Relationship/Capacity to Patient ____

Printed Name of Personal Representative ____

Printed Address & Telephone Number of Person Representative ____

MEDICARE QUESTIONAIRE

PATIENT NAME: ____

Please read each of the following and respond ONLY to those that apply to your current situation.

1. If you have received Home Health Care of any kind in the past 60 days, please provide the name and phone number of the Home Health Agency.

   HHA Name: _____________________________________ Phone: __________________________________

   Date Discharged for Home Health ________________________________

2. If you are entitled to benefits under Black Lung Program, Department of Veteran Affairs, or other government program, please provide the name, address, and phone number of that program.
   Program Name ____
   Address ____
   City, State, Zip ____
   Phone ____

   This government program will be primary to Medicare

3. Was your illness/injury due to any of the following:
   - ☐ Work Related — Accident Date: _______________________
   - ☐ Automobile Accident — Accident Date: _______________________
   - ☐ Accident on Property other than your own (example: store, restaurant, ect.) — Accident Date _______________________

   Please give details of the accident: ____
   ____

   Please provide the name, address, and contact information of the liability insurance:
   Insurance Name: ____
   Address: ____
   City, State, Zip: ____
   Phone: __________________________________Contact: ____

☐ **Please check here if none of the above apply**

Medicare regulations require us to file with the above liability insurance first, even if they will not pay directly or immediately. We must comply with this regulation before filing with Medicare.

PATIENT NAME: ____

PRIMARY INSURANCE: _________________________ SECONDARY INSURANCE: ______________________

☐ **DEDUCTIBLE:** A deductible is the amount you pay for health care services before your health insurance begins to pay. You will pay 100 percent of eligible health care expenses, like physical therapy, until you meet the deductible. Your plan's deductible is $_________________.

To date, you have met $__________________ of your deductible.

We estimate each visit to cost you $_______________ to go towards your deductible. We ask that you pay the estimated cost at each visit, until you have met your deductible.

☐ **OUT OF POCKET MAXIMUM:** Out of pocket maximum is the most you have to pay for covered services in a plan year. After you spend this amount on deductibles, copayments, and coinsurance, your health plan pays 100% of the costs of covered benefits. According to the information provided to us:

Your out-of-pocket maximum is $_________________

To date, you have met $________________________

☐ Covered 100% for 2022

☐ **COINSURANCE:** Coinsurance is your share of the costs of a health care services, like physical therapy. Its's figured as a percentage of the amount your insurance allows to be charged for services. You will start paying coinsurance after you've paid your plan's deductible. Based on past patients with your insurance, we estimate your _______% to be

$___________ per visit and we ask that you pay the estimated amount at each visit.

☐ **COPAY:** A copay is a fixed amount you pay for health care services, like physical therapy. All copayments are due at the time of service. If you would like, a credit card can be placed on file and charged each day you receive treatment.

Your copay is $_____________ per visit.

☐ **VISIT LIMIT:** Your insurance allows _________ visits per calendar year for PT/OT and based on the information we were given you have used __________ visits for the year.

☐ **VISIT LIMIT IS BASED ON MEDICAL NECESSITY**

Note: If you have a secondary insurance, we will submit your primary insurance Explanations of Benefits to them for coordination of benefits. At this time, we are not able to know exactly how your secondary will process your claim.

By signing, you are acknowledging that we have explained these benefits to you and have given you the opportunity to ask any questions regarding your financial responsibility.

Date Reviewed with Patient: ____________________

Patient or Guardian Signature: ____

Employee Signature: ____

This is an estimation of benefit coverage provided by your insurance company and is not a guarantee of benefits. Claim consideration by the insurance company supersedes the information quoted.

Palatka
Physical Therapy

PATIENT MEDICATION LIST

NAME: ____

MEDICATION	DOSAGE

PATIENT HEALTH INFORMATION

NAME:____

Please put a check in the box next to any medical conditions you may have or have had in the past

Musculoskeletal	Circulatory/Respiratory	Digestive	Nervous System
OSTEOARTHRITIS ☐	HEART CONDITION ☐	DIABETES ☐	STROKE/TIA ☐
RHEUMATOID ARTHRITIS ☐	HEART ATTACK ☐	KIDNEY PROBLEMS ☐	PARKINSON'S DISEASE ☐
POLYMYALGIA ☐	HEART ARRHYTHMIAS ☐	IRRITABLE BOWEL ☐	MULTIPLE SCLEROSIS ☐
LUPUS/SLE ☐	PACEMAKER ☐	BLADDER PROBLEMS ☐	EPILIEPSY/SEIZURES ☐
FIBROMYALGIA ☐	HIGH CHOLESTEROL ☐	LIVER PROBLEMS ☐	CONCUSSION/BRAIN INJURY ☐
CHRONIC FATIGUE ☐	BLOOD CLOTS/PHLEBITIS ☐	HERNIA ☐	NUMBNESS OR TINGLING ☐
OSTEOPOROSIS ☐	ANEMIA ☐	OTHER _______________.	OTHER: _______________.
HEADACHES/MIGRAINES ☐	OTHER: _______________.		
BULGING DISKS ☐		Infectious Disease	Skin
LEG CRAMPS ☐		TB ☐	SKIN ALLERGIES/RASHES ☐
JAW PAIN/TMJ ☐		HEPATITIS ☐	ECZEMA/PSORIASIS ☐
HISTORY OF FALLS ☐		POLIO ☐	INFECTIOUS SKIN DISEASE ☐
USE CANE/WALKER/CRUTCHES ☐		OTHER: _______________.	SHINGLES ☐
OTHER: _______________.			OTHER: _______________.

Please list any prior accidents, broken bones, or surgeries with approximate dates: ____________________________________

____

____

Have you had surgery for this injury? YES ☐ NO ☐ Surgery Date(s):____________________________________

When did your pain begin? (Date of injury)____

Have you had any medical or rehabilitative services for this injury/episode? YES ☐ NO ☐

Do you smoke? YES ☐ NO ☐

Are you pregnant? YES ☐ NO ☐

List any other information that would assist us in your care:____

____

Are you aware of what your diagnosis is? YES ☐ NO ☐

Based on your awareness, what are your expectations/goals while in therapy? ________________________________

____

Height________feet__________inches Weight______________pounds

____ ______________________________

PATIENT SIGNATURE DATE