

PATIENT DATA SHEET

PATIENT INFORMATION: (PLEASE COMPLETE ENTIRE FORM)

NAME: _____
LAST FIRST MI

ADDRESS: _____
STREET CITY STATE ZIP

PHONE: _____
HOME WORK CELL

EMAIL: _____ PREFERRED WAY TO CONTACT YOU: home work cell GENDER: male female

DATE OF BIRTH: _____ AGE: _____ SS# _____ married single divorced widowed

REFERRING PHYSICIAN: _____ PRIMARY CARE/FAMILY PHYSICIAN: _____

HOW DID YOU HEAR ABOUT US: FAMILY FRIEND PHONE BOOK INTERNET DOCTOR OTHER: _____

ARE YOU CURRENTLY RECEIVING PHYSICAL THERAPY OR HOME HEALTH? YES NO

EMPLOYER: _____ OCCUPATION: _____ EMERGENCY CONTACT & PHONE # _____
 Full time Part time Retired Unemployed Disabled Student

RESPONSIBLE PARTY INFORMATION: IF SELF CHECK HERE AND SKIP TO NEXT SECTION SELF

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ RELATIONSHIP TO PATIENT: _____
STREET CITY STATE ZIP

PHONE: _____ EMPLOYER: _____ SS# _____
HOME WORK CELL

INSURANCE INFORMATION:

Are you aware of your benefits? YES No

PRIMARY INSURANCE: _____ INSURED NAME: _____ See Copy of Card

POLICY#: _____ GROUP#: _____ RELATIONSHIP TO INSURED: Self Spouse Child Other

(If not the insured, please complete their information below)

INSURER'S EMPLOYER: _____ Date of Birth: _____ SS# _____

SECONDARY INSURANCE: _____ INSURED NAME: _____ See Copy of Card

POLICY#: _____ GROUP#: _____ RELATIONSHIP TO INSURED: Self Spouse Child Other

(If not the insured, please complete their information below)

INSURER'S EMPLOYER: _____ Date of Birth: _____ SS# _____

ACCIDENT INFORMATION: Was this injury the result of an accident? Yes No

MOTOR VEHICLE ACCIDENT WORK RELATED OTHER DATE OF ACCIDENT/INJURY: ____/____/____

HIPPA: By signing this form I acknowledge that I have been informed of the HIPPA "Notice of Information Practices" posted in the waiting room from Physical Therapy Center of Ocean Springs and understand it completely. I can request a copy of this form.

CONSENT: By signing this form, I agree and give my consent for Physical Therapy Center of Ocean Springs to furnish physical therapy care and treatment considered necessary and proper in diagnosing and/or treating my physical condition.

X _____
SIGNATURE DATE PARENT OR GUARDIAN IF MINOR DATE

PAST/CURRENT MEDICAL HISTORY

Have you ever had/been diagnosed with any of the following conditions?

- none
- cancer
- heart problems
- metal implants
- pacemaker
- heart defibrillator
- stroke
- HIV
- kidney problems
- thyroid
- epilepsy/seizure/dizziness
- Diabetes
- Arthritis
- circular/vascular problems
- infectious disease (i.e. hepatitis,tuberculosis,etc)
- list any other surgeries _____
- chemical dependency
- high blood pressure
- depression
- lung problems/ asthma
- incontinence
- blood disorder/ anemia
- multiple sclerosis
- allergies
- fractures
- stomach problems
- Parkinson's
- head injury
- spine problems/ surgery
- other _____

PREVIOUS FUNCTIONAL LEVEL

Independent in all activities (work, home, recreation)

Self Care

- Independent (bathing, toileting, dressing, etc)
- Difficulty in performing self care activities
- Need assistance with self care activities
- Difficulty in performing household chores

Social/Recreational/Leisure

Limited in _____

WORK HISTORY

- | | | |
|-------------------------------------|-----------------------------------|---|
| Employer _____ | Occupation _____ | |
| <input type="checkbox"/> full time | <input type="checkbox"/> self | <input type="checkbox"/> unemployed |
| <input type="checkbox"/> part time | <input type="checkbox"/> retired | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> terminated | <input type="checkbox"/> disabled | <input type="checkbox"/> student; if yes please list school name: _____ |

Physical activities at work

- sitting
- phone use
- heavy equipment operation
- crawling
- standing
- repetitive lifting
- climbing
- walking
- computer use
- driving
- heavy lifting
- bending

Current working status

- full duty
- restricted duty
- out on leave

If not performing your normal activities at work do you plan to return to your previous activity level? Yes No

If you were injured on the job, please describe how the incident occurred.

Patient/Guardian

Signature: _____

* M.D. follow up appointment: ____ / ____ / ____

Reviewed by Physical Therapist: _____
Date: ____ / ____ / ____

PATIENT FINANCIAL POLICY

This is an agreement between Physical Therapy Center of Ocean Springs (creditor) and the Patient (debtor) named on this form.

In this agreement the words "you", "your", and "yours" means the Patient (debtor). The word "account" means the account that has been established in your name to which charges are made and payments are credited. The words "we", "us", and "our" refer to Physical Therapy Center of Ocean Springs.

By executing this agreement, you are agreeing to pay for all services and supplies that are received.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately that previous balance, any new charges to the account, any new payments or credits applied to your account during the month. Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

Required Payments: Any copayments or coinsurance required by an insurance company must be paid at the time of service. We shall have the right to cancel your privilege to make charges against your account at any time and require that visits must be paid at the time of service.

Contracted Insurance: If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay, deductible, or co-insurance, you must pay at the time of service. As contracted providers with your insurance company, we agree to accept the allowable amount (usual and customary) established by your insurance company. Although we may estimate what your insurance company may pay and the patient responsibility portion, it is the insurance company that makes the final determination of payment and eligibility.

Non-Contracted Insurance: Insurance is a contract between you and your insurance company. It is the patient's responsibility to verify if our office is a contracted provider or non-contracted provider. As a non-contracted provider, there is no adjustment or write-off for the difference between what we charge and what the insurance allows. You agree to pay any portion of the charges not covered by your insurance.

Primary Insurance: If possible, we will verify your insurance benefits and eligibility during your first appointment. It is the patient's responsibility to be aware of your own benefits and eligibility. As a courtesy to you, we will bill your primary insurance; however, if our office has not received payment after 120 days, the balance will become patient responsibility unless other arrangements are made with us.

Secondary Insurance: As a courtesy to you, we will bill your secondary insurance after your primary insurance has paid. If our office has not received payment from your secondary insurance after 120 days from the date first billed to your secondary insurance, the balance will become patient responsibility unless other arrangements are made.

Referrals/Prescriptions/Authorizations: If your insurance company requires a referral, prescription, or pre-authorization, you are responsible for obtaining it. Failure to obtain the referral, prescription and/or preauthorization may result in a lower payment, or no payment from the insurance company.

Workers Compensation: We require approval/authorization by your worker's compensation carrier prior to your initial visit. We will obtain this as a courtesy for you. We will also obtain approval/authorization for your follow up appointments. It is your responsibility to provide us with accurate information in order to contact your carrier.

Personal Injury/ Motor Vehicle Accidents (MVA): If you are being treated as part of a personal injury lawsuit or claim, we may require verification from your attorney. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges, we may consider accepting a letter of protection. If you have Personal Injury Protection/Medical Payment through your motor vehicle insurance, we will bill them as primary insurance and will bill your private health when your vehicle insurance exhaust.

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Benefit Assignment: You assign all medical benefits to us including health insurance, Medicare, auto insurance, worker's compensation, or other insurance plans. You also authorize Physical Therapy Center of Ocean Springs to release all information necessary (including photocopies of medical records) to secure payment (see Notice of Privacy Practices). You agree that if insurance pays directly to you, this monetary amount is actually due and is patient responsibility.

Billing Information: It is your responsibility to provide us with correct information including insurance, responsible party, date of injury, type of accident, policy and /or group numbers, etc. Should the information change, it is your responsibility to update it within a timely manner. If you supply us with incorrect information, the balance will be your responsibility. We will not be responsible for rebilling, appealing or other dealings with newly provided insurance information.

Medicare: We are a participating Medicare Part B provider. We will bill Medicare and your supplemental carrier (if applicable). Physical Therapy services can only be performed on a Medicare patient that has been seen by their referring physician every 90 days. This means that you must follow up with your physician every 90 days for Medicare benefits to apply. Medicare does not pay for supplies or durable medical equipment provided by Physical Therapist. In the event it is required to issue you a supply, you will be asked at that time to sign a Medicare Waiver Statement and pay for the supply. You will also be informed of the Medicare Cap Limits for Physical Therapy on a separate sheet.

Methods of Payment: We accept Visa, MasterCard, Discover, personal checks and cash. We do not carry change. If paying cash, it must be the exact amount. There is a fee of \$25.00 for any check returned by your bank.

I have been informed of my financial responsibility and agree to the terms and conditions as stated on this form.

Patient Name: _____

Responsible Party (if patient is a minor):

Signature: _____

Date: _____