

Alton Physical Therapy, P.C.

Getting people better one patient at a time and we'll start today.

Today's Date _____

Patient's

Last/First _____

Email _____

Address _____

Referring Physician _____

City _____ State _____ Zip _____

Primary Physician _____

Home Phone _____

Next MD Appt _____

Work Phone _____

DX/Chief Complaint _____

Cell Phone _____

SSN _____

Date of 1st. Symptom or Injury _____

Sex _____ Date of Birth _____

Was this an accident? Yes No

Employment Status: FT PT Retired Student Umpl

Accident Type Work Auto Other

Marital Status _____

If this was an accident,

Employer _____

Date of accident _____

Employer Address _____

State in which accident occurred _____

City _____ State _____ Zip _____

Occupation _____

Rate you pain level from 0-10. 0 = No pain 10 = Worst

Are you or think you may be pregnant? Yes No

Now: _____

Do you have a pacemaker? Yes No

At worst: _____

In Case of Emergency, Please Contact:

At best: _____

Name _____

Medications: _____

Relationship _____

Home Phone _____

Cell Phone _____

Surgical History _____

Please Provide Insurance cards to Office Staff and fill in information below if the Insured is not SELF.

Primary Insurance

Secondary Insurance

Insurance Co. _____

Insurance Co. _____

Insured's Name _____

Insured's Name _____

Address _____

Address _____

City _____ State _____ Zip _____

City _____ State _____ Zip _____

SSN _____ DOB _____

SSN _____ DOB _____

Relationship to Patient _____

Relationship to Patient _____

Employer _____

Employer _____

Consent to Medical and related Health Care: I request and consent to the medical care and treatment procedures as determined necessary by my physician(s). I acknowledge the care I receive while in this facility is under the direction of my physician(s).

Medical and Allied Health Care Providers: I have been informed and understand that the Physical Therapist providing services to me in this facility are not independent contractors and are employees of this facility unless otherwise specifically identified.

Teaching Programs: I understand this facility may, from time to time, enter into agreements with academic programs. Because of these agreements, physical therapy students may participate in my care. I agree to participate in these programs, but have the right to limit my participation at any time.

Patient Rights: I acknowledge access to the Patient Rights information explaining my rights as a patient at this facility.

Personal Property: I have been informed and understand this facility will not be liable for any loss of my personal property unless it is inventoried and placed in a secured area maintained by this facility.

Payment for Medical and Related Care, splints and durable medical equipment (DME): I agree to pay the charges incurred for the care I received as ordered by my physician(s) at this facility. I guarantee full payment of all charges unless restricted by Medicare. These charges include, but are not limited to if necessary, to stabilize an emergency medical condition. In the event that I fail to pay these charges, I understand that I will be responsible for reasonable collection costs and attorney fees associated with the cost of resolving my account.

Assignment of Benefits: I hereby irrevocably assign and transfer to THIS FACILITY any and all benefits, either contractual, common law, or statutory, to which I am entitled or which are available to me under any medical, health, and accident, or workers' compensation policy, plan, or program. I hereby authorize and direct that any such payments be paid directly to THIS FACILITY. Should my insurance policy, or plan description, prohibit direct payment to providers, I direct the Payor to issue the provider a check payable to THIS FACILITY and myself. I further authorize and agree that a copy of this authorization shall be deemed valid as the original.

Cancellations or Late Arrivals: Appointments are made to save the patient time and prevent unnecessary waiting and delay. Many people are inconvenienced when an appointment is missed you, every patient following you and the therapist. If for any reason this appointment cannot be kept or you will be arriving late, notification should be made as far in advance as possible. Your attention to this matter will be greatly appreciated.

I have read and understand the above agreement.

Patient/Responsible Party Signature

Relationship

Date

If Patient is a minor:

I give consent for treatment of the above named minor child by Alton Physical Therapy. P.C. and or its affiliated offices.

Parent/Legal Guardian Signature

Date

Witness:

Facility Employee Signature

Date

Medicare Part B

Patient Name: _____ Date: _____

Medicare requires us to ask you a few questions. Please answer below.

With Whom do you live:

(Check all that apply) _____ Alone
_____ Spouse/Significant Other
_____ Child/Children
_____ Other Relative(s)
_____ Group Setting
_____ Personal Care Attendant
_____ Other: _____

Where do you live? _____ Private Home
_____ Private Apartment
_____ Rented Room (board and care/assisted)
_____ Living/Group Home
_____ Homeless (with or without shelter)
_____ Long-term Care Facility (Nursing Home)
_____ Hospice
_____ Other: _____

Have you received any outpatient Physical Therapy this year? Yes No

If you answered yes, we need the following information:

- a.) Where did you receive your treatments? _____
b.) We need the total Medicare allowed amount \$ _____

Are you **currently** receiving any type of Home Health Care? Yes No

If you answered yes, **we cannot treat until discharged.**

Have you received any type of Home Health Care this year? Yes No

If you answered yes, we need the following information.

- a.) Where did you receive your treatments? _____
b.) What is your discharge date? _____

Have you received Speech Therapy this year? Yes No

If you answered yes, we need the following information:

- a.) Where did you receive your treatments? _____
b.) We need the total Medicare allowed amount \$ _____