Orthopedic & Occupational Physical Therapy

David Heap, PT
Karen Heap, PT
Jennifer Maggio, PT

Patient Information

Patient Name: _____ SS#: _____Birth Date: _____

Physical Address: _____ City, State, Zip: _____

Mailing Address: _____City, State, Zip: _____

Preferred Telephone #: _____ ☐ Preferred Cell#:_____

☐ M ☐ F ☐ Single ☐ Married ☐ Other _____ ☐ Employed ☐ UnEmployed ☐ Retired ☐ Disabled ☐ Student

Would you like an appointment reminder? ☐ Call ☐ Text ☐ E-mail

E-mail address: _____

Have you ever had Physical Therapy before? ☐ Yes ☐ No If so, when: _____

Is this accident related? ☐ No ☐ Yes, _____

Are you currently or have recently been under the care of a home health agency? ☐ No ☐ Yes, please list the name and phone number of the company:_____

Referring Physician: _____ Telephone: _____

How did you hear about us? ☐ Returning patient ☺ ☐ Physician ☐ Family Member ☐ Friend ☐ Other _____

Emergency Contact: _____ Telephone: _____ Relation: _____

Primary Insurance: _____

Are you the Guarantor? ☐ Yes ☐ No – If NO, please fill out information below.

Guarantor's Name: _____DOB: _____ SS#_____ ☐ M ☐ F

Telephone: _____ Address: _____

Patient Relation: ☐ Spouse ☐ Parent/Guardian ☐ Other

Secondary Insurance:

_____

Are you the Guarantor? ☐ Yes ☐ No – If NO, please fill out information below.

Guarantor's Name: _____DOB: _____SS#_____ ☐ M ☐ F

Telephone: _____ Address: _____

Patient Relation: ☐ Spouse ☐ Parent/Guardian ☐ Other

I have read and verified the above information is correct and true.I hereby consent to treatment and authorize the release of pertinent medical information to my physician(s), insurance carrier(s), and O^2 Physical Therapy.

_____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY IF MINOR DATE

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FINANCIAL POLICY

In order to reduce confusion and misunderstanding between our patients and the office, we have adopted the following financial policy. If you have any questions, please discuss them with our patient account representative. We are dedicated to providing the best possible care to you and regard your complete understanding of our financial policies as an essential element of your care and treatment.

- **Payment is due at the time of service** unless other arrangements have been made in advance. We will look to the adult accompanying a minor for payment of all services rendered to minor patients.
- Your insurance is an agreement between you and your insurance company. As a courtesy to you, we will review your insurance benefits and file your insurance claims for you.
- If your account becomes delinquent after repeated attempts by our office to collect, we will send your account to a collection agency. You will then be responsible for an additional 35% collection fee.
- **MEDICARE PATIENTS:** As required by CMS, treatment sessions provided in the office setting is 2-3 times/week for 12-18 visits and requires the professional skills of a qualified physical therapist to perform or supervise the treatment. Services continuing beyond these parameters will be based on the complexity of the case.

You are responsible for notifying the receptionist of all scheduled doctor appointments.

_____ _____
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY IF MINOR DATE

NOTICE OF PRIVACY PRACTICES

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- ✓ Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment and follow-up among the multiple healthcare directly and indirectly.
- ✓ Obtain payment from third-party payers.
- ✓ Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time-to-time, and that I may contact this organization at any time at the address above to obtain a current copy of this notice. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations.
I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

I have carefully read and understand my rights outlined in the *Notice of Privacy Practices* above.

_____ _____
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY IF MINOR DATE

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MEDICAL HISTORY FORM

Patient Name: _____ Date of Birth: _____

Estimated Height: _____ Estimated Weight: _____

Please check any conditions listed that you are experiencing and/or have experienced:

_____ Heart Problems
_____ High Blood Pressure
_____ Low Blood Pressure
_____ Chest Pain and/or Discomfort
_____ Bowel / Bladder Incontinence
_____ Other: _____

_____ Diabetes
_____ Headaches/Migraines
_____ Epilepsy
_____ Seizures
_____ HIV / AIDS

Please comment on any conditions checked above:

_____

_____

Do you have a pacemaker? ☐ Yes ☐ No

Please list any surgeries:

_____

_____

Please list medications you are taking **pertinent** to this diagnosis:

_____

_____

Please list any medications you are taking **NOT related** to this diagnosis:

_____

_____

I hereby consent to treatment and authorize the release of pertinent medical information to my physician and/or insurance carrier(s).

Patient Signature: _____ Date: _____

Therapist Signature: _____