PATIENT INFORMATION

Name _____ Soc. Sec. #_____- _____- _____
Last Name First Name Initial

Address _____

City _____ State _____Zip code _____

E mail address _____ Sex M F Age _____ Birth date _____

Home phone _____Mobile phone _____Work phone _____

In case of emergency who should be notified? _____Phone_____

Have you received Home Care Services recently? _____ Date _____ Agency _____

Have you received physical therapy in the past year? _____ Date _____ Number of sessions _____

Date of your last Doctor visit _____Whom may we thank for referring you? _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Initial

Relationship to Patient _____Birth date _____Soc. Sec #. _____-_____-_____

Address (if different from patient's) _____Phone _____

City _____State _____ Zip code _____

Insurance Company _____Insurance ID # _____

SECONDARY INSURANCE

Subscriber Name _____Relation to Patient _____Birth date _____

Address (if different from patient's) _____Phone _____

City _____ State _____Zip code _____

Insurance Company _____Insurance ID # _____

PATIENTS NAME:_____

MEDICAL HISTORY: Therapist Initials: _____

	YES	NO		YES	NO		YES	NO
HEART OR CARDIAC			DIABETES			SPRAIN MUSCLE		
HIGH BLOOD PRESSURE			SHORTNESS OF BREATH			ARTIFICIAL JOINT		
HEART ATTACK			EMPHYSEMA/ASTHMA			FRACTURED BONE		
PACEMAKER			CANCER			COMMUNICABLE DISEASE		
CHEST PAIN WITH ACTIVTY			CURRENTLY PREGNANT					
HISTORY OF STROKE			ALLERGIES					

Please list the following

List of Medication:_____

_____

_____

_____

_____

List of Allergies _____

_____

_____

Surgery History_____

_____

_____

_____

Bone Fracture History_____

_____

_____

_____

FINANCIAL POLICY

Thank you for choosing PhysioSource, Ltd. as your health care provider. We are committed to your treatment and your health. However, as a small business, please understand that timely payment for health services rendered is vital to our company – this helps us to control costs and continue to provide for the health of our patients. This financial responsibility obligates you to ensure full payment of your bill – by your insurance or other means. Therefore, all patients will be required to establish financial arrangement for payment of their account.

Regarding Insurance Payment and Coverage – PhysioSource requires your co-payment and deductible payment at time of treatment. PhysioSource will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges and "usual and customary" charges. You agree to check into your insurance benefits booklet, and verify your benefits with your insurance. PhysioSource, Ltd. will contact your insurance provider to confirm your coverage benefits. However, PhysioSource will not be held responsible for any coverage errors your insurance company may have misquoted. PhysioSource does not take responsibility for your insurance coverage or knowing what your individual insurance benefits are. Any charges that are not covered by your insurance company are your responsibility.

Self pay – If you are a self pay patient with no Insurance coverage, you are expected to pay in full on each visit.

Regarding Insurance Billing – As a service to you, PhysioSource will bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill. If, after 60 days, your insurance provider has not responded to or paid for any claims submitted by PhysioSource, Ltd., you understand that 50% of the account balance would be due, and a monthly payment would be established at that time. If your account becomes delinquent and requires it to be turned over for collections you are obligated to pay the original balance owed and reimburse PhysioSource, Ltd. for all costs incurred by it in the collection of said debt. ***Regardless of insurance coverage, you are ultimately responsible for the timely payment (in full) of services that were provided to you*.** If paying by check you understand and authorize all dishonored checks plus a processing fee of **$30.00**.

Appointment No-Shows: Any patient who fails to arrive for a scheduled appointment without cancelling the appointment at least four hours prior to the scheduled time is considered a "no-show". A no-show patient will be charged **$30.00**, for failure to show. A patient who is a no-show three times will be discharged from the practice and the referring physician will be notified.

Appointment cancellations: A patient that has cancelled 50% of their scheduled appointments, without rescheduling those appointments, will be discharged from the practice and the referring physician will be notified.

Minors –The adult accompanying minor is responsible for payment.

Payments – PhysioSource accepts cash, check, MasterCard, Visa, Discover and American Express.

I have read the above Financial Policy and (regardless of my insurance status) I am ultimately responsible for the balance of my account for any professional services rendered by Physiosource, Ltd.

_____

Patient's Signature and (or) Authorized Representative Date

_____

Patient's Name (Print) and (or) Authorized Representative

Consent regarding Physical Therapy Evaluation and Treatment

I understand that the physical therapy requested by my referring physician and rendered by PhysioSource, Ltd. may involve a variety of treatment methods. I understand the primary goal of my rehabilitation program is to reduce the symptoms of my condition and to improve my ability to function on a daily basis, at work and/or at home. I understand in order to achieve these goals my program will become progressively more extensive as my capability and endurance to therapeutic activities improve. As a result, I realize that the length of each therapy session may vary from 45 to 90 minutes depending on my ability to efficiently progress in my individualized physical therapy program.

Although every precaution will be taken when the therapy is administered to avoid an adverse physical reaction, I realize that there are risks involved in any type of physical activity. These risks include, but are not necessarily limited to, a general increase in my existing symptoms, muscle soreness, muscle strain, muscle and/or joint inflammation and in rare instances, electrical or thermal burns, frost bite, muscle and/or ligament tears and other joint damage. I realize it is my responsibility to inform the therapist of any changes in the signs and symptoms I am experiencing, and that I have the right to refuse any treatment and/or test if I feel it may be harmful. I understand I must first be assisted or instructed by a therapist before beginning any part of my therapy program, exercises, equipment, or modalities in the office. I understand the components of the services at PhysioSource, Ltd. completely and I hereby give consent to begin the therapeutic physical therapy program.

Please read and indicate that you have read the below by placing your initials by each statement.

_____ I authorize the release of all necessary information to my primary care and/or referring physician.

_____ I authorize the release of all necessary information to my Insurance Company(ies) to secure the payment of benefits to PhysioSource, Ltd.

_____ I authorize insurance payment benefits directly to the PhysioSource, Ltd.

_____ I authorize the release of my information to _____ in regards to my care and/or status of treatment.

_____ I have read this form and regardless of my insurance status I am financially responsible for all fees regardless of insurance coverage

_____ I have read this form and agree to all consent regarding physical therapy treatment and evaluation.

By signing below I agree to have read and understand the above information.

Patient's Signature or Authorized Representative

_____ Date:_____

Name of Authorized Representative (Print) (if applicable)

_____

Name of Patient (Print): _____

Date of Birth of Patient: _____

Patient Privacy Information

I give consent for PhysioSource, Ltd to contact me in the following manner:

[] Home Telephone_____
- [] O.K to leave message with detailed information
- [] Leave message with call back number only

[] Cell Telephone_____
- [] O.K to leave message with detailed information
- [] Leave message with call back number only

[] Work Telephone_____
- [] O.K to leave message with detailed information
- [] Leave message with call back number only

[] Written Communication
- [] O.K to mail to my home address
- [] O.K to fax to this number

[] Electronic Communication
- [] O.K. to email appointment reminders to the email address you provided unencrypted.
- [] O.k. to text appointment reminders to your cell number listed above

I acknowledge I have been shown or given a copy (if requested) of the Notice of Privacy Practices from PhysioSource, Ltd. If there are any question regarding this notice I can contact the privacy manager at 419-724-5580.

PhysioSource, Ltd may have patients exercise sheets/computer charts out in the clinic thus enabling staff to document while the patient is being treated. Please speak to your therapist and or office staff if this is a concern.

Patient Signature_____ Date_____

Signature of parent/guardian _____ Date_____