ELIMINATE PAIN • IMPROVE MOVEMENT • RETURN TO ACTIVITY

PATIENT INFORMATION

(Please Print Clearly)

NAME:_____ DATE OF BIRTH:_____/ _____/_____
First MI Last

HOME ADDRESS:_____
Street Apt# City State Zip

MAILING ADDRESS:_____
Street Apt# City State Zip

PHONE #:_____ _____ _____
Home Cell Work + Ext.

SOCIAL SECURITY #:_____ GENDER: ☐ M ☐ F MARITIAL STATUS: ☐Married ☐Single ☐Divorced ☐Widowed

RESPONSIBLE PARTY / GUARANTOR (RP)

(If you are not the patient but responsible for charges – Please check relationship below)

☐Guardian ☐Spouse ☐Power of Attorney ☐Other: _____

RP NAME:_____ DATE OF BIRTH:_____/ _____/_____
First MI Last

HOME ADDRESS:_____
Street Apt# City State Zip

MAILING ADDRESS:_____
Street Apt# City State Zip

PHONE #:_____ _____ _____
Home Cell Work + Ext.

SOCIAL SECURITY #:_____ GENDER: ☐ M ☐ F MARITIAL STATUS: ☐Married ☐Single ☐Divorced ☐Widowed

INSURANCE

("Subscriber" is the person who holds the insurance plan whether personally or through their employer. Please also provide a copy of your insurance card(s) to our receptionist)

SUBSCRIBER'S NAME:_____ DATE OF BIRTH:_____/ _____/_____
First MI Last

RELATIONSHIP TO PATIENT:_____

PRIMARY INS.:_____
COMPANY ID/Policy # Group # Customer Service Ph #

SECONDARY INS.:_____
COMPANY ID/Policy # Group # Customer Service Ph #

TERTIARY INS.:_____
COMPANY ID/Policy # Group # Customer Service Ph #

IS YOUR INJURY RELATED TO: ☐Worker's Compensation (WCOMP) ☐Motor Vehicle Accident (MVA) ☐Other Personal Injury ☐VA

(If your case is related to Worker's Compensation or MVA/Personal Injury, another form will be provided to fill out to ensure accurate claim submission and processing)

Have you had Physical Therapy, Occupational Therapy, Speech Therapy or Chiropractic visits previously *this* year? ☐ Yes ☐ No ☐ PT ☐ OT ☐ ST ☐ Chiro

Where?:_____ **Roughly How Many Visits?**_____

MINOR CONSENT

(If patient is a minor)

_____ *Please Initial* – I hereby authorize this PT clinic and/or it's Individual Therapists and Assistants to evaluate and administer PT treatments to the minor patient listed above. This authorization is in effect as of the date this form is signed. This authorization shall remain valid for current and future PT cases until written notice is given by me revoking said authorization. I understand that I am financially responsible for all services rendered to the above patient whether I am present at the time of treatment or not.

ACKNOWLEDGEMENT: By signing below I acknowledge that all of the information listed above is true and accurate to the best of my knowledge; I authorize the release of any medical information in order to process my claims as accurately as possible; I am requesting services and agree to charges being rendered to my insurance; I understand that I am responsible for copays (due at time of service) and any remaining balance after insurance processes my claims; I understand I am ultimately responsible for knowing my insurance benefits and that any information given to this clinic is not a guarantee of payment and only an outline of my benefits provided to this clinic by my insurance company.

_____

Patient/Guardian Signature (Guardians *must* sign for minors) **Date**

Attending Clinic Location(s) – OFFICE USE ONLY:

☐ Hamilton PT ☐ Hamilton PT at The Canyons ☐ Darby PT ☐ Corvallis PT ☐ Stevi PT ☐ PT Specialists of Florence ☐ Frenchtown PT ☐ Drummond PT

PATIENT MEDICAL HISTORY FORM

Name:_____ Date of Birth:_____ Date:_____

Circle Yes or No

Have you or any immediate family member ever been told you have . . .

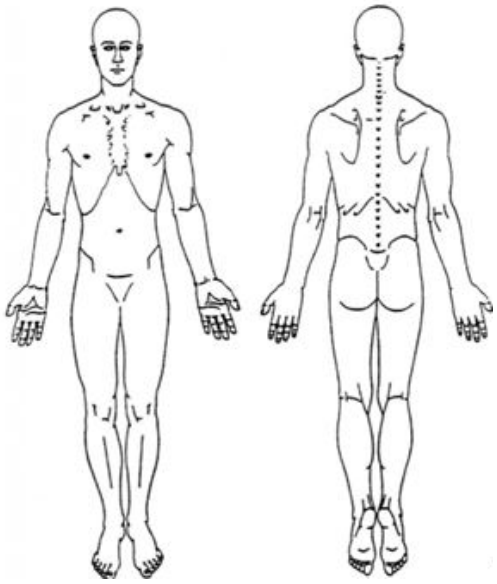
	SELF		FAMILY	
Cancer?	Yes	No	Yes	No
Diabetes?	Yes	No	Yes	No
High blood pressure?	Yes	No	Yes	No
Heart disease?	Yes	No	Yes	No
Angina/Chest pain?	Yes	No	Yes	No
Stroke?	Yes	No	Yes	No
Osteoporosis?	Yes	No	Yes	No
Osteoarthritis?	Yes	No	Yes	No
Rheumatoid arthritis?	Yes	No	Yes	No
Bleeding disorders?	Yes	No	Yes	No

In the past 3 months have you had or do experience:

A change in your health?	Yes	No
Nausea/Vomiting?	Yes	No
Fever/Chills/Sweats?	Yes	No
Unexplained weight change?	Yes	No
Numbness or tingling?	Yes	No
Changes in appetite?	Yes	No
Difficulty swallowing?	Yes	No
Changes in bowel/bladder function?	Yes	No
Shortness of breath?	Yes	No
Dizziness?	Yes	No
Upper respiratory infection?	Yes	No
Urinary tract infection?	Yes	No

Please rate your pain over the last 24 hours
0 being no pain, 10 being the worst pain you've ever experienced.

Circle your answer… 0 1 2 3 4 5 6 7 8 9 10



Please mark on the body chart where you have pain.

Date Updated: _____

Patient's Initials:_____

Do you have any allergies to medications?
Yes.....No
List_____
_____
_____
List previous surgeries and dates._____
_____
_____
List medications you are currently using: _____
_____
_____

Do you have a history of:

Allergies/asthma?	Yes	No
Headaches?	Yes	No
Bronchitis?	Yes	No
Kidney disease?	Yes	No
Rheumatic fever?	Yes	No
Ulcers?	Yes	No
Sexually transmitted disease?	Yes	No
Seizures?	Yes	No
Do you have a pacemaker?	Yes	No
Do you have any metal in your body?	Yes	No

Where? _____

Are you currently:

Pregnant?	Yes	No
Depressed?	Yes	No
Under Stress?	Yes	No

Are your symptoms: (check one)
□Getting worse □The same: how long? _____
□Improving

How are you able to sleep at night? (check one)
□Fine □Moderate difficulty
□Only w/ Medication

Check all that apply…..
Do you have a problem with…?
□Hearing □Vision
□Speech □Communication

Have you consulted an attorney for your current Problem? .....Yes .....No

Preferred learning method….
□Verbal □Written □Demonstration

Do you, or have you in the past smoked tobacco?
Yes No
If yes, _____ packs X _____ years
Last tobacco use _____

Do you drink alcoholic beverages?.....Yes .....No
If yes, how many drinks do you routinely have per week?
_____/week.

Date of last physical examination _____

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Physical Therapy Clinic Policies and Conditions of Services

Patient Name: _____

Thank you for choosing us as your physical therapy provider! We are committed to providing you with quality and affordable health care. Please read our clinic policies below and ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance:** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. It is also your responsibility to know whether or not pre-authorization is required. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Self Pay, Copays, and Deductibles:** All copays and deductibles must be paid at the time of service or in advance. This arrangement is part of your contract with your insurance company. Failure on our part to collect copays and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your copay at each visit. If you have no insurance, we do expect payment at the time of service unless you have made other arrangements with our billing department. For minor patients, the parent, relative, or other individual, escorting the patient is responsible for any payments due at the time of service and for the balance remaining after insurance has processed your claim.

3. **Non-covered Service:** Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare of other insurers. You must pay for these services in full at the time of service.

4. **Proof of Insurance:** All patients must complete our patient information form before seeing a therapist. We must obtain a copy of your current insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the charges you incur.

5. **Claims Submission:** The PT Clinic will attempt to obtain payment from your insurance carrier, worker's compensation plan, or motor vehicle insurance. It is our policy to complete an initial claim form and submit it to your carrier. We will assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. If monthly payments are required, please speak with our billing department.

6. **Coverage Changes:** If your insurance changes, please notify us prior to your next visit so we can make the appropriate changes to help you receive your maximum benefits.

7. **Nonpayment:** I understand that I am personally responsible for paying all collection fees associated with my account, including reasonable attorney fees and reasonable collection agency fees. I understand that in the event my account is turned over to a third party collection agency, a collection fee in the amount of up to 50% of my total account balance will be added to my balance and that I am responsible for paying my total account balance plus the collection fee.

8. **Non-Sufficient Funds Checks:** Our policy is to attempt to secure funds from all checks written. If they fail on the first attempt, our bank will automatically send your check through a second time. If it is returned to us we charge a $30.00 fee. The check would need to be covered by cash, credit card, or money order within 5 business days of our notice or it may be presented to our collection agency.

9. **Authorization and Assignment of Benefits:** By signing below I hereby assign, transfer, and set over to the PT Clinic and/or its individual therapists, all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information required to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

10. **High Deductibles:** Patients who have a deductible of $1,000.00 or more are asked to pay $100.00 at each physical therapy visit. This payment will be applied toward charges for each date of service. Please note that the patient responsibility for each visit will be determined by benefits of your insurance plan and will exceed $100.00. A statement for the remaining account balance will be sent at the beginning of each month. Please discuss your care with your physical therapist. For available options regarding your account please contact our Billing Department for assistance.

11. **Cancellation / No-Show Policy:** Our goal is to provide patients with an excellent therapy experience. We strive to provide the best possible care available. To better serve our patients, our cancellation / no-show policy will be left up to our individual treating therapist's discretion.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for reviewing our payment policy. Please let us know if you have any questions or concerns.

I have read and understand these clinic policies, including the Notice of Privacy Practices and the Assignment of Benefits, and agree to abide by its terms. I also understand that these policies can change at any time, for any reason without notice.:

_____ _____

Signature of Patient or Responsible Party **Date**

PATIENTS WITHOUT INSURANCE

Self/Direct-Pay: By signing below I state that I or the minor patient ***DO NOT*** have health insurance and will be responsible for services rendered here at Hamilton Physical Therapy, P.C. I agree to pay the clinic in which I attend Physical Therapy the full and entire amount of treatment given to me or to the above-named patient at each visit.

_____ _____

Signature of Patient or Responsible Party **Date**

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HIPAA - Notice of Privacy Practices

Congress passed the Health Insurance Portability and Accountability Act, or HIPAA, in 1996. Its primary purpose is to ensure that people who change jobs cannot be denied health insurance in a new job because of a pre-existing health condition. The law also established minimum standards of privacy and security to ensure that sensitive information about individuals' health would remain confidential.

I hereby acknowledge that I have received and have been given an opportunity to read a copy of the clinic's Notice of Privacy Practices (NPP). I understand that if I have any questions regarding the Notice or my privacy rights, I can contact the clinic's HR department at (406) 375-9034; or by email at hradmin@hamiltonpt.com.

I acknowledge that I have been given an opportunity to review the NPP, and that it is available in hard copy upon request. I also understand that the NPP is available on the practice's website at hamiltonpt.com, darbypt.com, corvallispt.com, stevipt.com, florencept.com, frenchtownpt.com or drummondpt.com and a copy is available to me at the clinic's front desk.

Please note that if the appropriate boxes are not checked for everyone listed below, we legally cannot speak with said individuals regarding your appointments and/or account. Thank you for your understanding

EMERGENCY CONTACT:

Full Name:_____

DATE OF BIRTH :_____/ _____/_____

Relation to Patient: _____

Phone #: _____

☐ Okay to release information pertaining to my treatments/records (including any appointments you may have).

☐ Okay to release information pertaining to my account regarding all billing inquiries.

ADDITIONAL CONTACT:

Full Name:_____

DATE OF BIRTH :_____/ _____/_____

Relation to Patient: _____

Phone #: _____

☐ Okay to release information pertaining to my treatments/records (including any appointments you may have).

☐ Okay to release information pertaining to my account regarding all billing inquiries.

Consent for Use of Text Message & E-Mail

Your attending clinic location would like to make increasing use of new technologies to communicate with patients. In order to deliver care to you as efficiently as possible, and for your convenience, it is often helpful to communicate with you over the phone through texting and emailing. Please be advised, however, that communicating over texting and email is inherently unsecure. We take your privacy very seriously, and therefore we may only communicate with you in these ways with your informed consent.

Please indicate below whether and to what extent we can communicate with you utilizing these methods. Participation in these types of communications is entirely voluntary. In communicating with you using these methods, we will always limit your protected health information to the minimum information necessary. We will also only contact you using these methods for matters related to your healthcare.

If at any time you would like to opt out of these services, please make a written request to the practice(s) you are currently being seen at and we will discontinue utilizing these communication methods.

MOBILE NUMBER (Text Message Appointment Reminders):_____ ☐ Yes ☐ No

E-MAIL ADDRESS (Communication Via Email):_____ ☐ Yes ☐ No

Patient or Legal Guardian: _____ **DATE OF BIRTH :**_____/ _____/_____
(Printed Name)

Patient or Legal Guardian: _____
(Signature - Legal guardians *must* sign for minors)

Relationship: _____ **Date:** _____

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