Creekside Physical Therapy Patient Form

Name ____ Birthdate __________ Age ________

Address ____
Street City State Zip

Mailing Address ____
Street City State Zip

Home Phone ______________Work Phone ________________ Email _________________❑ Male ❑ Female

Social Security # ______________________________ Driver's License # _____________________

Employer ______________________________ Employer's Address ____

Spouse or Parent Name ____

Spouse or Parent Employer ____

Employer Address ____
Street City State Zip

If you are a student what is your permanent address and phone number?

____
Street City State Zip Phone Number

Name of relative or friend not living with you ______________________________ Phone ___________________

Method of Payment ❑ Cash ❑ Private Insurance ❑ Medicare ❑ Worker's Comp

If you have Medicare do you have a secondary insurance? ❑ Yes ❑ No

If yes, name of insurance __________________________

If you have private insurance please provide the following information (disregard if we have a copy of your insurance card)

Name of Insurance ____

Address ____

Phone _________________________Subscriber's Name ______________________

Subscriber's ID #_______________________ Group _________________________

- I hereby authorize Creekside Physical Therapy, Inc. personnel to provide treatment as prescribed by my physician.
- I hereby assign all insurance benefits (or services rendered to which I am entitled) to be paid directly to Creekside Physical Therapy, Inc. I understand that if my insurance company/third party payer denies payment or makes partial payment, that I am responsible for the balance.
- I hereby authorize the release of medical records to Creekside Physical Therapy, Inc. and pertinent information concerning the patient for the provision of care and for obtaining insurance reimbursement.

THE FOLLOWING DOES NOT APPLY TO WORKER'S COMPENSATION CLIENTS

- I understand that I am legally responsible for payment for all services rendered by Creekside Physical Therapy, Inc. If my insurance is being billed, I will be responsible for paying any remaining balance not covered by the insurance company and for any co-payments/deductible amounts. I understand that co-payments are due at the time of service.

____ ________________________

Signature of Patient (Parent or Guardian if under 18) Date

Credit Policy

WELCOME! The following credit policies were made to establish and maintain a good patient-therapist relationship.

As a courtesy, we are happy to bill your insurance company. Please read your policy to become fully aware of any limitations of the benefits provided for outpatient physical therapy. If a worker's compensation insurance company covers physical therapy, you as the patient will not be liable for any related charges. If you do not have insurance coverage we will be more than happy to arrange a financial payment plan to suit your needs, as well as ours.

We ask that you look upon your insurance as a device, which reimburses you for physical therapy expenses. Our obligation is to submit all billings pertaining to your claim. If you have a co-payment we ask that you make it at the time of each service.

If you are unable to keep an appointment please contact us as soon as possible, preferably with 24 hours advanced notice. Missed appointments without 24-hour advance notification may result in a service charge.

We are pleased you have chosen Creekside Physical Therapy, Inc. and look forward to serving you. Our number one priority is to provide professional care in a comfortable setting. Feel free to talk with us about any special needs or concerns your may have about your visits with us.

I have read and completely understand the above information.

____
Patient Name

____ _______________
Signature of Patient or Personal Representative Date

Creekside

Physical Therapy

Athletic Training * Aquatic Therapy

1. Describe the main problem that leads you to physical therapy. If you are having physical therapy because of a surgery, list the type of surgery. If you had an accident, please describe:

   ____

2. How long have you had this problem? If your therapy is related to a surgery or accident please list.

   ____

3. Do you have other related problems that require physical therapy? ❑ Yes ❑ No
   If yes, describe:

   ____

4. What seems to aggravate your condition or symptoms?

   ____

5. What seems to relieve your condition or symptoms?

   ____

6. List and describe functional activities which you cannot perform or have difficulty performing.

   ____

7. What is your current occupation? ______________________

   Has your condition affected your work? ______________________

   ____

8. Have you had any testing or treatment for this condition? ❑ Yes ❑ No
   If yes describe:______________________________________

9. If your therapy is related to a surgery, describe any treatment you have had since surgery:

   ____

10. Describe your overall health

    ____

11. Do you have or have you had any of these conditions?

    ❑ Yes ❑ No Diabetes
    ❑ Yes ❑ No High Blood Pressure
    ❑ Yes ❑ No Heart Disease
    ❑ Yes ❑ No Heart Attack
    ❑ Yes ❑ No Pacemaker
    ❑ Yes ❑ No Headaches
    ❑ Yes ❑ No Metal Implants
    ❑ Yes ❑ No Previous Surgery (related to condition)
    ❑ Yes ❑ No Kidney Problems
    ❑ Yes ❑ No Nervous Disorders
    ❑ Yes ❑ No Sensitivity to Heat/Ice
    ❑ Yes ❑ No Currently Pregnant
    ❑ Yes ❑ No Allergic to Meds
    ❑ Yes ❑ No Seizures
    ❑ Yes ❑ No Cancers

    If you answered yes to any of these conditions, give a brief explanation:

    ____

12. List all current medications and for the condition(s) requiring the medication(s):

    ____

Consent to the Use or Disclosure of Protected Health Information for the Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by Creekside Physical Therapy, Inc. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Creekside Physical Therapy, Inc.

I understand that diagnosis or treatment of me, by Creekside Physical Therapy, Inc. may be conditioned upon my consent as evidenced by my signature of this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Creekside Physical Therapy, Inc. is not required to agree to the restrictions that I may request. However, if Creekside Physical Therapy, Inc. agrees to a restriction that I request, the restriction is binding on Creekside Physical Therapy, Inc.

I have the right to revoke this consent, in writing, at any time, except to the extent that Creekside Physical Therapy, Inc. has taken action in reliance on this consent.

My “protected health information” means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Creekside Physical Therapy, Inc.’ Notice of Privacy Practices prior to signing this document.

The Creekside Physical Therapy, Inc. Notice of Privacy Practices has been provided to me.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Creekside Physical Therapy, Inc.

This Notice of Privacy Practices also describes my rights and the duties of Creekside Physical Therapy, Inc. with respect to my protected health information.

Creekside Physical Therapy, Inc. reserves the right to change the privacy practices that are describe in the Notice of Privacy Practices.

I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy to be sent in the mail or asking for one at the time of my next appointment.

____
Signature of Patient or Personal Representative

____
Name of Patient or Personal Representative

____
Date

____
Description of Personal Representative’s Authority