Harmeling PHYSICAL THERAPY

Date

Date of Birth

Name

Employer

Address

Address

City, State, Zip

City, State, Zip

Telephone

Work Telephone

Email

Primary Care Physician

Referring Physician

Type of injury: Employer related_____Auto accident_____Home_____Unknown_____Other_____

Date of injury/onset:_____

**Have you ever had physical therapy before? Yes_____No_____

If yes, during your Benefit Year of _____? Yes_____No_____ How many visits?_____

**Are you currently having home health care services of any kind? Yes _____ No _____

In case of emergency notify: Name_____Telephone(_____)_____-_____

Attorney (if any)_____Telephone(_____)_____-_____

Insurance Company

Secondary Insurance (if any)

Subscriber (name of cardholder)

Subscriber (name of cardholder)

Subscriber Date of Birth

Subscriber Date of Birth

Policy or Claim # Group #

Policy or Claim # Group #

Subscriber's Address if Different From Patient

Subscriber's Address if Different From Patient

**Who will be responsible for any expenses not covered by insurance? _____

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HOW DID YOU HEAR ABOUT US?

PREVIOUS PATIENT _____ DOCTOR _____ INTERNET SEARCH _____ FRIEND/FAMILY MEMBER _____

COMMUNITY EVENT _____ OTHER _____

PLEASE READ THE FOLLOWING CAREFULLY
THEN INITIAL, SIGN AND DATE BELOW

CANCELLATION AND NO SHOW POLICY

AFTER TWO "NO-SHOWS", THE REMAINDER OF YOUR APPOINTMENTS WILL BE CANCELLED. 24 HOUR NOTICE IS REQUIRED FOR CANCELLATION. MULTIPLE CANCELLATIONS WILL RESULT IN THE TERMINATION OF THERAPY.

Initial_____

INSURANCE REFERRALS/AUTHORIZATION

I understand that if I am a member of a private health insurance that requires referrals and or authorization for physical therapy that for each treatment for which I do not have a referral or authorization to be seen, I will be responsible for payment for services rendered should these treatments be denied by my health insurance carrier.

****IF YOU HAVE AN HMO OR MEDICARE YOUR BENEFIT IS LIMITED. ****
PLEASE ASK FOR DETAILS.

Initial_____

PATIENT BILL OF RIGHTS

I have been provided a copy of the Patient Bill of Rights or have chosen to read the copy posted in the waiting area. I understand my rights as a patient outlined in this document.

Initial_____

ELIGIBILITY AND BENEFITS

It is the responsibility of the patient or responsible party to confirm their eligibility and benefits with their health carrier. You are responsible for contacting your insurance carrier to establish what your individual benefit is for services rendered. As a courtesy, Harmeling Physical Therapy and Sports Fitness, Inc. (hereafter Harmeling PT) checks eligibility and benefits on all patients however we cannot be held responsible for misquoted benefits.

Initial_____

FINANCIAL RESPONSIBILITY

I understand that I and/or my family are responsible for all services rendered by Harmeling PT. I further understand that I am financially responsible for, and agree to pay, all deductibles, as well as any copays and/or other co-insurance not covered by my or my dependent's insurance carrier. **Copay payments will be collected upon arrival at each treatment.**

ASSIGNMENT OF BENEFITS

I hereby assign and authorize payment of all medical benefits directly to Harmeling PT, to include major medical benefits to which I, or my dependents, am entitled including Medicare and other government sponsored programs, private insurance and any other health plans for all charges incurred by me or my dependent. I hereby authorize Harmeling PT to release any and all information necessary to secure payment of said benefits.

RELEASE OF INFORMATION

I hereby authorize Harmeling PT to disclose or obtain all or any part of my, or my dependent's record, to or from any person or corporation which may be liable for all or part of the charges of Harmeling PT including but not limited to insurance companies, doctors, legal counsel, workers compensation carriers, or employers.

I HAVE READ AND UNDERSTOOD THE ABOVE

SIGNATURE: _____DATE:_____
PATIENT (or parent if patient is a minor)

Health Questionnaire

Please **circle** if you have or had any of the following:

Osteoarthritis/Rheumatoid arthritis	Blood Disorders	Heart problems
High Blood Pressure	Neuromuscular Disease	Stroke
Broken Bones	Circulation problems	Seizures
Breathing problems/Asthma	Infectious Diseases	Osteoporosis
Thrombophlebitis (blood clots)	Balance problems	Diabetes
Stomach/GI problems		

Other: (please list) _____

Please **circle** one:

Do you have a pacemaker/defibrillator?	YES	NO
Are you or could you be pregnant?	YES	NO
Do you take a Vitamin D supplement?	YES	NO
Are you allergic to latex?	YES	NO
Do you have any form of active cancer?	YES	NO

Please list:

_____

Please list all **allergies** that you have:

_____

Please list all **medication** you are currently taking (and what they are for)*:

*A Current list of prescriptions can be substituted for this list, please give to our administrative staff to photocopy for your case.

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please list all **surgeries** you have had:

SURGERY	**DATE**
_____	_____
_____	_____
_____	_____
_____	_____

What are your **goals** for physical therapy?

_____

_____

_____

_____

Patient Signature: _____ Date: _____