

Patient Information Sheet

First Name: _____ Last: _____ MI: _____ Gender: M / F

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth _____ SS# _____ - _____ - _____ Marital Status: **M S W D**

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Circle your preferred method of contact: Home Phone Work Phone Cell Phone Email

Email Address: _____ Nickname: _____

Employer: _____ Occupation: _____

Employment Status (circle) Full Time Part Time Retired Not Employed Student(Full or Part Time)

Emergency Contact: _____ Phone: _____

How did you hear about Legacy Physical Therapy? (Please circle all which apply)

Physician referral Phonebook Internet Physical location Scheduling Service

Friend/Family Member _____ Other _____

Referring Doctor: _____ Next Dr. Appointment: _____

Primary Insurance: _____ Subscriber Name: _____ D.O.B _____

Relation to patient: _____ ID #: _____ Group #: _____

Address of subscriber (if different than above): _____

Secondary Insurance: _____ Subscriber Name: _____ D.O.B _____

Relation to patient: _____ ID #: _____ Group #: _____

Address of subscriber (if different than above): _____

Signature: _____ **Date:** _____



OFFICE POLICY

Legacy PT Forms/Consent Form/February 2016

CONSENT FOR TREATMENT

I, the undersigned, do hereby agree and give my consent for LEGACY PHYSICAL THERAPY, LLC to furnish medical care and treatment considered necessary and proper in evaluating and treating my physical condition.

ASSIGNMENT OF BENEFITS

I hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, and private insurance, and third party payers to LEGACY PHYSICAL THERAPY. I hereby authorize LEGACY PHYSICAL THERAPY to furnish information to insurance carriers concerning this treatment and I hereby assign all payment for services rendered.

PATIENT/GUARDIAN SIGNATURE _____ Date _____

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FINANCIAL POLICY STATEMENT

We bill your insurance carrier solely as a courtesy to you. You are responsible for your bill. If you change insurance coverage while undergoing treatment, it is your responsibility to notify the office of this change. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you may be responsible for the amount of money refunded to your insurance company.

If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit same to LEGACY PHYSICAL THERAPY, LLC.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

Your insurance benefits as quoted to us by your insurance carrier have been reviewed with you. We assume no liability for any errors made by your insurance carrier in this quotation. We have reviewed these benefits with you and you agree to pay your portion of this bill.

Workers' Compensation Claims: If you claim workers' comp benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered.

Cancellation & No Show Policy: We require 24 hours notice in the event of a cancellation. The charge for cancellation without proper notice is \$30. The charge is not covered by insurance and is due before your next appointment.

Co-payments & Deductible: Per our guidelines, co-payments and payment toward deductible are due at the time of service.

Insufficient Funds: Checks returned for Insufficient funds may be subject to a \$25 processing fee.

The above information has been explained to me. I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

PATIENT/GUARDIAN SIGNATURE _____ Date _____

Center Representative Signature _____ Date _____



Summary Notice of Privacy Practices

Legacy Physical Therapy is committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your medical information and to provide you with notice describing:

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW THE FOLLOWING CAREFULLY

“Protected health information” is information about you, including demographic information, present or future physical or mental health or condition and related health care services. We are required by law, in most instances, to have your written consent before we use or disclose to others your medical information for the purpose of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.

We may sometimes use or release your information without your consent or authorization as may be required or permitted by certain laws.

You have the right to the following:

- Look at and make copies of your protected health information
- Ask us to not release parts of your protected health information
- To be told when we release your protected health information
- Ask us to contact you only in certain ways
- Request us to change parts of your protected health information
- File a complaint if you think your rights have been violated

THIS IS ONLY A SUMMARY

We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligations under the law. We may revise our notice from time to time. You have the right to obtain a copy of our most recent Notice in effect. Please ask the front desk if you wish to receive a full copy of our Notice of Privacy Practices.

If you have any questions, concerns, or complaints about the Notice or your protected health information, please contact Brooke Kalisiak, PT, DPT, at (636) 225-3649.

My signature below indicates that I have been provided with the summary Notice of Privacy Practices and I am aware that I may obtain the most recent copy of the Notice of Privacy Practice in its entirety at the front desk or by calling (636) 225-3649.

Signature of Patient/Guardian

Date

Legacy PT Forms/ HIPPA/April 2011

Patient Medical History

Name: _____

Describe the problem(s) for which you seek physical therapy. (Continue on the back of sheet if needed)

What makes your symptoms better? _____

What makes your symptoms worse? _____

Please list any prescription or non-prescription medications you take. (Continue on the back of sheet if needed)

Do you currently or have you ever had any of the following? (please check all that apply)

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Emboli | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Osteopenia | <input type="checkbox"/> Prostate Disease |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Emotional problems | <input type="checkbox"/> Pelvic Inflammatory Disease | <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Energy Loss | <input type="checkbox"/> Severe Headaches | <input type="checkbox"/> Menopause |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Seizures | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Bladder problems | <input type="checkbox"/> Frequent fainting | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Pins or metal implants |
| <input type="checkbox"/> Blood clot | <input type="checkbox"/> Goiter | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Bowel Problems | <input type="checkbox"/> Gout | <input type="checkbox"/> Stroke | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hearing difficulties | <input type="checkbox"/> Swollen joints | <input type="checkbox"/> Fibroids |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart attack/problems | <input type="checkbox"/> Thyroid trouble | <input type="checkbox"/> Ovarian Cysts |
| <input type="checkbox"/> Chemotherapy/radiation | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Hernia | <input type="checkbox"/> Vision difficulties | _____ |
| <input type="checkbox"/> Coronary Heart Disease | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Weakness | _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Weight loss | _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Numbness/tingling | <input type="checkbox"/> Broken Bones | _____ |

Past Surgical History: Please list surgeries. _____

Please rate your current level of health on a scale from 0-10. 0 1 2 3 4 5 6 7 8 9 10

(0= not at all healthy, 5=moderately healthy, 10=Picture of Health)

Do you have a pacemaker? Yes No

Are you pregnant? Yes No

Do you smoke? Yes No

If Yes, Due Date: _____

List any other information that would assist us in your care: _____

What are your goals for Physical Therapy? _____

Patient/Guardian Signature: _____ Date: _____