Returning Patient Information Sheet

Name: ____ Gender: M / F Marital Status: **M S W D**

Referring Doctor: _________________________ Next Dr. Appointment: __________________________

Emergency Contact: ________________________________ Phone: ___________________________

HAS ANY OF YOUR CONTACT INFORMATION CHANGED SINCE WE LAST SAW YOU?????

Phone #: ___Yes ___ No New Home #: __________________ New Cell #:___________________

Address: ___Yes ___ No New Address: ____

Email Address: ___Yes ___ No New Email Address: ____

Employer: __________________________________ Occupation:________________________________

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

HAS ANY OF YOUR INSURANCE INFORMATION CHANGED SINCE WE LAST SAW YOU???

_____**YES** (Fill in below) **or** _____ **NO**

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

CONSENT FOR TREATMENT

I, the undersigned, do hearby 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 nearby 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 hearth 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 PHYSICAL THERAPY

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)

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

Past Surgical History: Please list surgeries. ____

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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

Do you smoke? ☐ Yes ☐ No

Are you pregnant? ☐ 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:________________