Harbor Physical Therapy Patient Information Form

DEMOGRAPHICS

Date ______ Date of Birth ______ Social Security Number ______

Circle One: MALE FEMALE

First Name ______ MI ______ Last Name ______

Street/P.O. Box Address ______ City ______ State ______ ZIP ______

Home Phone Number ______ Cell Phone Number ______ Email ______

APPOINTMENT REMINDER: ___**Call Home#** ___**Call Cell#** ___**Text Cell#** ___**No Reminder**

HOW DID YOU HEAR ABOUT US? ☐ **Facebook/Social Media** ☐ Friend ☐ Doctor ☐ Web Search

Employed / Unemployed / Retired ______
Employer / Occupation / Work Number

Emergency Contact Name, Relationship, Phone Number ______ Parent/Guardian (if under the age of 18) ______

INJURY/BODY PART INFORMATION

For which body part are you being seen today? ______

Date of injury OR approximate date that symptoms started? ______

Surgery: ___**YES** ___**NO** Date of surgery/name of surgeon: ______

Have you ever had an EMG, Angiograph, Ultrasound, MRI, CAT scan, or X-rays of your injured areas? If so, when and where? ______

Which Physician referred you to Physical Therapy? ______

Who is your Primary Care Physician (PCP)? ______

Is this condition related to (circle one): Employment Auto Accident Other ______

INSURANCE INFORMATION:

Primary Insurance Company ______ Member ID Number ______ Group Number ______

Subscriber Name: (Self, Spouse, Parent, Other) ______ Subscriber's SSN ______ Subscriber's Date of Birth ______

Secondary Insurance Company ______ Member ID Number ______ Group Number ______

Subscriber Name: (Self, Spouse, Parent, Other) ______ Subscriber's SSN ______ Subscriber's Date of Birth ______

HARBOR PHYSICAL THERAPY

CONDITIONS OF BILLING

Please read carefully and sign below where indicated.

1. **Assignment of insurance benefits**: I hereby assign all appropriate benefits and proceeds to Harbor Physical Therapy for application on my bill; I understand that any portions of my treatment not covered by insurance, including co-pays, are my responsibility.

2. **Financial Agreement**: I promise to pay for services rendered to me. Should this account be turned over to collections, I understand that I shall be responsible for any fees and/or collection expenses.

3. **Outside Services**: I understand that I may be billed separately for services such as equipment supply and/or rental that are not included in the regular cost of therapy.

SIGNED: ____________________________ DATE: ___________________

CANCELLATION & NO-SHOW POLICY

You will be charged $25 for missed appointments and/or cancellations made without 24 hours prior notice. However, you will not be charged if you are able to reschedule your treatment during an existing opening on the same day.

FOR MEDICARE PATIENTS ONLY

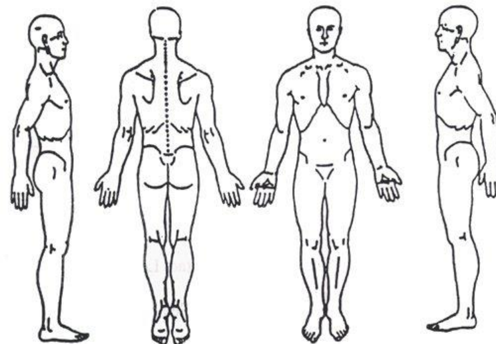
I certify that information given by me in applying for payment under the appropriate laws of the social security act of HB 89-97 is correct. I authorize release of any information needed to act on this request. I request that payment of authorized benefits be made on my behalf. I assign payment of the unpaid charges of the therapists for whom Harbor Physical Therapy is authorized to bill in connection with its services. I understand that I am responsible for any health insurance deductibles and 20% of the remaining reasonable charges. I request that this authorization apply throughout the period of treatment.

SIGNED:____________________________ DATE:___________________

MEDICARE PATIENTS: If you are a Medicare patient, your PCP must certify physical therapy every 10th visit and every 30 days after your initial visit. Your PCP may require that you see him/her for a re-evaluation to certify continued therapy. Initial: ____________

On the diagram, please mark the location of your symptoms… (pain, muscle tightness, tension, stiffness, swelling, spasm, etc)

Height:__________
Weight:__________
BMI:____________



Name______________________________

R5/99:kjb