New Patient Form

Therasport

Date _____

Patient Information

Patient's Name _____
Last Name First Name Middle Name Name you go by

Street _____

City, State, Zip _____ Home Phone _____ Cell Phone _____
include area code include area code

Sex _____ Birth Date _____ Age _____ SSN _____ Driver's Lic. # _____ Marital Status _____
mm/dd/yyyy

Patient's Employer _____ Occupation _____ Work Phone _____
include area code

Spouse's Name _____
Last Name First Name Middle Name Name goes by

Spouse's Employer _____ Occupation _____ Work Phone _____
include area code

Emergency Contact

Contact's Name _____ Relationship _____ Phone _____
include area code

Referring Provider

Referring Provider _____

Insurance Information

Insurance #1 _____

Group # _____ Contract # _____ Co-pay _____

Name of Insured _____ Relationship to Patient _____

Sex _____ Birth Date _____ SSN _____
mm/dd/yyyy

Insurance #2 _____

Group # _____ Contract # _____ Co-pay _____

Name of Insured _____ Relationship to Patient _____

Sex _____ Birth Date _____ SSN _____
mm/dd/yyyy

Authorization to Release Information and Assignment of Benefits

**Return to Dr Date: _____

**Do you wish to receive appointment reminders by email? Y or N
If Yes, please provide email adcres: _____

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Signature _____ Date _____

I hereby authorize Therasport to apply benefits on my behalf for the covered services rendered by the office, or by the office's order. I request that payment from my insurance company be made directly to Therasport or to the party who accepts assignment.I certify that the information I have reported with regard to my insurance coverage is correct.

Signature _____ Date _____

TheraSport Physical and Aquatic Therapy
Medical History Form

By answering the following questions, the therapist will be able to provide a safe and effective treatment plan.

Referring Physician: _____ **Primary Care Physician:** _____

Problems to be treated: _____

Have you ever had treatment for this problem before? YES / NO

Have you had outpatient physical therapy this calendar year? YES / NO

Have you received home health services? YES / NO
****If so, please write date of discharge from home health agency** _____

List any other major illness or surgery that has occurred in the past year:

_____

_____

Do you now have/or have you at any time had any of the following?

High Blood Pressure	Y/N	Headaches	Y/N	Kidney Problems	Y/N
Heart Disease	Y/N	Allergies	Y/N	Nervous Disorders	Y/N
Heart Attack	Y/N	Hernia	Y/N	Hearing Problems	Y/N
Diabetes	Y/N	Seizures	Y/N	Balance Problems	Y/N
Sensitive to Heat/Ice	Y/N	Metal Implants	Y/N	Vision Problems	Y/N
Dizzy Spells	Y/N	Cancer	Y/N	Pacemaker	Y/N
Pregnant	Y/N				

If YES on any of the the above, please explain: _____

_____

Do you need any assistance with any of the following?

Transportation	Y/N	Domestic Chores	Y/N	Meals	Y/N
Shopping/errands	Y/N	Personal Care	Y/N	Other: _____	

Has your illness/disability caused any of the following?

Financial Problems	Y/N	Family Problems	Y/N	Emotional Problems	Y/N

The information above is correct to the best of my knowledge

_____

Signature **Date**

THERASPORT
PHYSICAL AND AQUATIC THERAPY

Dr. Mindi Meadows Posey
PT, DPT, MS, ATC

P.O. Box 1966
Rainsville, AL 35986

Phone: 256.638.1150
Fax: 256.638.1158

TheraSport Physical and Aquatic Therapy

HIPPA Acknowledgement/Consent

Patient Name: _____

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for TheraSport, Inc. In addition, I hereby consent to the use and disclosure of my personal health information for the purpose of treatment, payment and health care operations.

_____ _____

Signature of Patient or Authorized Representative **Date**

If representative, print name and relationship:

_____

I also acknowledge and understand that it is the standard practice of physical therapy to have treatment in an open treatment area with other patients, but agree that it is my responsibility to let the treating therapist know if I prefer to be treated in a privacy room or curtained area. All employees at TheraSport, Inc. have been thoroughly trained in the importance of privacy and draping techniques to protect your privacy at all times.

_____ _____

Signature of Patient or Authorized Representative **Date**

If representative, print name and relationship:

_____

Welcome to TheraSport Physical and Aquatic Therapy!!!

Please take a minute to review our payment policies. The office manager will be happy to answer any questions you may have. ***<u>**PLEASE NOTE OUR POLICIES HAVE CHANGED AS OF 6-14-12.**</u>

Payment Policies
All charges that you incur at our office are your responsibility. You may pay for your charges at each visit or choose to use our insurance filing service. There is not extra charge to use this service, however you must agree to the following terms:

On your first visit, you will be required to pay any unmet deductible and co-insurance. We request that you pay your co-insurance at each visit.

The billing department will file all insurance claims for you. Your insurance company must allow you to have reimbursement payments sent directly to us. If your insurance does not allow this, we require that you pay for all treatment at the time of visit.

Financial Responsibility
We will bill your insurance company daily and use our best efforts to obtain payment. However, any charges that remain unpaid for 60 days after the billing become your responsibility to pay. We will send you a monthly statement which will notify you of any charges that your insurance company declines to pay. It will also inform you of payments made by your insurance company and you and of your present balance. If your accident results in a litigation process, payment must be made on a monthly basis until settlement is reached. After settlement is concluded, payment is due in full.

_____
INITIALS

Payment Arrangements
We have an agreement with your insurance company to charge you your deductible and co-insurance, but understand that sometimes it is not possible to pay all of your balance at once. If you would like to make specific payments on your balance over a set period of time, we offer payment arrangements. Please speak with the office manager if you would like to set up a payment arrangement.

_____
INITIALS

Collections
If you have made no attempt to pay after six billing cycles, your account will be turned over to a collection agency. We give you every opportunity to pay and set up payment arrangements.

_____
INITIALS

Appointment Cancellations
To prevent our patients from waiting for treatment, we do not overbook appointment times. Please give us 24 hours when canceling appointments. We often have a waiting list of patients who may need a specific time of day for their appointments.

Please Initial One

_____ I would like to use the insurance filing service of this clinic and agree to the terms above.

_____ I would prefer to file my own insurance claims and will pay my bill in full at each visit.

I have read and understand the payment policies of TheraSport Physical and Aquatic Therapy.

_____ _____
Signature Date

Patient Name:_____

Patient DOB:_____

Medication List

REQUIRED FOR MEDICARE PATIENTS

Medication Name	Medication Dosage	Frequency Taken
1		
2		
3		
4		
5		
6		
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