



9757 Westpoint Drive
Suite 200
Indianapolis In 46256
317-845-5400 Phone
317-713-1211 Fax

Patient Information

Patient Name (Full): _____ Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Birth date: _____
Sex: M F Marital Status: (circle one) Single Married Widowed Divorced Separated
Social Security #: _____ Occupation: _____
Employer _____ Employer Address: _____
Referring M.D.: _____ Date of Return Visit to MD: _____
Email: _____

FINANCIALLY RESPONSIBLE PERSON

Insured: _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Birth date: _____
Employer _____
Employer Address: _____ City: _____ State: _____ Zip: _____
Other person to notify in emergency: _____ Phone: _____

MEDICAL INSURANCE COVERAGE

Primary Insurance Company: _____
ID/Policy #: _____ Group #/Name: _____ Subscriber: _____
Secondary Insurance Company: _____
ID/Policy #: _____ Group #/Name: _____ Subscriber: _____
Workman's Comp. Insurance Company and Billing Address: _____

Employer: _____ Claim #: _____ Date of Injury: _____
Claims Adjuster: _____ Phone: _____

ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL INFORMATION: (Please read and sign)

I hereby authorize payment of medical benefits to PHYSICAL THERAPY SPECIALISTS LLC, for services rendered to my dependents or myself. I also authorize the release of any medical information that is necessary to process Medicare and/or insurance claims. I understand that I am responsible for any amount not covered by insurance. I understand that a copy or facsimile of this authorization can be used in place of the original. This assignment will remain in effect until revoked by me in writing.

Patient Signature: _____ **Date:** _____



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CONDITIONS OF TREATMENT

1. **PATIENT RESPONSIBILITY:** As a patient receiving medical care, you should be aware of your insurance coverage and limitations. Many insurance companies require pre-authorization for physical therapy treatments. It is my responsibility to determine insurance benefits and that Physical Therapy Specialists will assist me in obtaining the necessary pre-authorizations when needed. Failure to obtain necessary pre-authorizations may result in a reduction or rejection of benefits by the insurance company.
2. **ASSIGNMENT OF INSURANCE BENEFITS:** I authorize my insurance company to pay Physical Therapy Specialists, LLC directly. **I understand that I am responsible for charges not covered by my insurance company including late penalty charges.** I agree that a photocopy of this authorization is as effective and valid as the original.
3. **CONFIDENTIALITY:** Confidential information expressly identifies the medical nature of the services rendered to a patient, and includes all information and records obtained in the course of treatment. It includes information from history and physical examination.
4. **MEDICARE AUTHORIZATION; PATIENT'S CERTIFICATION AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST:** I certify that the information given in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about the patient named below to release such information to the Social Security Administration, its intermediaries, or carriers, effective from this date to indefinite.
5. **NO SHOWS/ CANCELLATION POLICY:** **I will be charged a \$25.00 fee for no show appointments and cancellations within 24 hours.**

POLICY ON PATIENT ACCOUNTS

1. **PRIMARY INSURANCE:** We will be happy to bill your insurance for you if you provide us with the appropriate billing information. Your insurance will make payment directly to Physical Therapy Specialists and you will be responsible for any deductible, co-payments or other patient balances. If you have a balance on your account, you will receive a monthly statement until the account is paid in full.
2. **PAYMENT OPTIONS:** Payment options include cash, check, Visa and MasterCard.
3. **SECONDARY/SUPPLEMENTAL INSURANCE:** We bill the majority of secondary/supplemental insurance companies. Please check with the office manager if you wish your secondary/supplemental insurance automatically billed.
4. **All bills are due and payable upon receipt of your monthly statement.** If you have special financial needs, please feel free to discuss this with our Office Manager in order to establish an extension of credit terms.
5. Past due accounts will be assigned to an outside agency for collection and reviewed by the Office Manager for further action.

I have read and understand this financial agreement. I have had an opportunity to ask questions and accept the responsibility of its terms.

Patient/Responsible Party

Date



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HEALTH HISTORY FORM

Name: _____ Age: _____

List your chief complaint and health problems that you would like addressed: _____

Aggravating Factors: Sitting Walking Coughing Exercise Rest
 Other: _____

Alleviating Factors: Sitting Walking Exercise Rest Other

Explain: _____

Medications (all prescription and non-prescription): _____

Surgeries: _____

Imaging, X-rays, MRI, CT (specify by name, dates and results if known): _____

Exercise when injury free (list recent activities, as well as future goals):

Do you have any of the following medical conditions?

- | | | |
|------------------------|------------------------------|-----------------------------|
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Epilepsy | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| GI Disorders | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| High Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bladder Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bowel Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hernia | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Pacemaker | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Pregnant (possibility) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Other medical problems not listed above:

Describe the intensity of your pain: (0 is no pain. 10 is excruciating.) Circle the number that corresponds to your pain.

0-1-2-3-4-5-6-7-8-9-10