NEW PATIENT INTAKE FORM

PATIENT INFORMATION

PATIENT NAME: *Last*:________________ *First*:_____________ *MI*: _________DATE OF BIRTH: ____/____/______

SS#_________-______-____________ Circle One : Sex: *M/F* Marital Status:____________

ADDRESS:____APT #:_____________________

CITY:__________________ STATE: ____________________________ ZIP:____________________

PHONE: HOME:_____________________ WORK_______________________ CELL: _____________________

EMPLOYMENT STATUS: *(circle)* full time part time retired unemployed student p/t student f/t

REFERRING DR.: ______________DATE OF INJURY: ____________ DATE OF SURGERY: _______________

Is your condition related to: **EMPLOYMENT**: Y / N **AUTO ACCIDENT**: Y / N

Have you ever been a patient at any One-On- One Facility? Y / N *If yes, when:*_________________

Are you currently, or have you at anytime received treatment for ***this or any other injury (treatment includes*** *therapy at another office,* ***home care*** *and chiropractic services)* ? Y /N

If yes, please list: ____

INSURANCE INFORMATION

NAME OF PRIMARY INS.: ____________________________ PHONE: _________-___________-___________

INSURED:_____________________ REL. TO INSURED: ________________INSURED DOB: ____/_____/______

INSURED SS#: _______-_____-___________POLICY / ID #:________________ GROUP #: __________________

INSURED'S ADDRESS (if different from above): ____

CITY:________________________ STATE: _________ ZIP: _____________________APT.#_______________

INSURED'S EMPLOYER: __________________ ADDRESS:____

SECONDARY INS.: ____________________________ PHONE: (________)-___________-___________

INSURED:_____________________ REL. TO INSURED: ________________INSURED DOB: ____/_____/______

INSURED SS#: _______-_____-___________POLICY / ID #:________________ GROUP #: __________________

INSURED'S ADDRESS (if different from above): ____

WORKERS' COMPENSATION / NO FAULT INFORMATION

Carrier Case Number / Claim #: ______________________ POLICY #: ___________________

Insurance Carrier: ____

Insurance Address: ____

City:____________________ State: _________ Zip:__________________________

Claims Representative:____________________ Phone: ________________________________

Name of employer:_______________________ Address:_______________________________

Are you currently working with a case nurse? Y/N If yes, Name:_________________________

Phone: _____________________________________

Are you currently working? Y/ N If no, as of what date have you been unable to work:______

Attorney Name:__________________________ Phone:________________________________

BASIC MEDICAL HISTORY

Please inform us of any medical conditions we should be aware of (ie: pace maker, heart condition, diabetes, pregnancy, etc):

____

____

Are you currently taking any medications? If yes please list:

____

____

How did you hear of One On One Physical Therapy:

____

PATIENT INSURANCE ASSIGNMENT / AUTHORIZATION STATEMENT

Welcome to ***One on One Physical Therapy****. Thank you for choosing our facility for your Physical Therapy Needs. We offer the option of Insurance Assignment strictly as a courtesy to our members, and as such, our members must understand and agree to the following:*

1. That you are considered a cash member until you bring in your insurance card and this office both qualifies and accepts your coverage. 2. That you must pay deductibles and co-pays in full. 3. That if your carrier has not paid a claim within 60 days of submission you are responsible to take an active part in the recovery of your claim. 4. That if for any reason your insurance company requires additional information or documentation you will provide it.
5. That if payment from the insurance company is not granted due to lack of information, misinformation, coverage expiration or is made directly to you, you are responsible to make payment to One On One. 6. That for bounced checks there is a charge in addition to the charge due of $25 to cover bank fees. 7. That you are aware that verification of coverage does not guarantee payment of our fees if the Insurance company requests additional information in order to pay the claim you will provide it in a timely manner.

I request that payment of authorized insurance payments be made on my behalf to One on One Physical Therapy and Rehabilitation for any service furnished me by that physician/supplier. I authorize any holder of medical information about me to release to One-on-One and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payments be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA 1500 form, or elsewhere on other approved claim forms or electronically submitted claims my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

I have read and understand this policy:
If patient is a minor, parent or guardian must sign below as responsible party

______________________ ______________________ ______________
Patient/ Responsible Party (please print) *Signature* *DATE*

WORKERS COMPENSATION / NO FAULT PATIENT AGREEMENT

In the event I fail to prosecute the claim for Workers' Compensation / No Fault for the illness I am receiving treatment, do not comply with producing information that is requested from me, or if my carrier denies payment of my claims determining the condition I am receiving treatment for is not related to the claim I have presented, I am aware that I will be held financially responsible for the claims. If my benefits are exhausted I must notify One On One, and provide them with my private insurance information. If I fail to do so I will be held financially responsibility.

I have read and understand this policy:
If patient is a minor, parent or guardian must sign below as responsible party

______________________ ______________________ ______________
Patient/ Responsible Party (please print) *Signature* *DATE*

PATIENT HIPAA AWARENESS

With my permission, One On One Physical Therapy may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to One On One Physical Therapy's Notice of Privacy Practices for a complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. One On One Physical Therapy reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the office of One On one Physical Therapy may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my permission, the office of One On One Physical Therapy may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards, and patient statements as long as they are marked Personal and or Confidential.

With my permission, the office of One On One Physical Therapy may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that One On One Physical Therapy restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this, I am allowing One On One Physical Therapy to use and disclose my PHI for TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

____

Signature of Patient or Legal Guardian

____ _______________

Patient's Name Date

____

Print Name of Patient or Legal Guardian

PHYSICAL THERAPY ATTENDANCE POLICY
PLEASE READ THOROUGHLY

One-on-One Physical Therapy and Rehabilitation strives to provide each patient with the highest quality of care while attempting to accommodate your schedule for your convenience. Therefore, we provide reserved time slots for each patient with a specific therapist in order to minimize your waiting time and assure continuity of your treatment. Your consistent attendance of the planned treatment regimen is paramount to your full recovery.

While we are sensitive to the fact that an emergency may occur in a rare instance, cancellations, especially last minute ones, along with patient no-shows, decrease our ability to accommodate the scheduling needs of other patients. We must ask for your full cooperation with the following policy:

- If you are unable to keep a scheduled appointment, we request that you notify us no later than the prior workday (before 4PM), so your appointment can be rescheduled.
- All cancellations and no-shows will be documented in your medical record and appropriately reported to your physician and insurance/third party payer.
- If you accumulate 3 cancellations or no-shows, your therapist may place you on the "schedule based on availability lists". This will require you to call for an open appointment on each day you would like to receive therapy. We will do everything we can to accommodate you, as space on the schedule permits.
- This office does not take walk-ins. If you do not have an appointment scheduled and you show up at the office, you will not be treated. Therefore it is recommended for your benefit that you take appointment cards to confirm your appointment. Patients who arrive 15 minutes late for their appointment may be rescheduled.

We believe that this policy is necessary for the benefit of all of our patients, so that we may provide high quality treatment and service to everyone.

All One-on-One Physical Therapy and Rehabilitation staff and patients appreciate your anticipated adherence and cooperation with this policy.

Good Luck with your rehabilitation. We are here to help you attain all of your goals and optimize you to work……to play…..to live.

______________________________ ________________________

Patient Acknowledgement /Signature Date

PATIENT’S AUTHORIZATION SIGNATURE FORM

BLUE SHIELD
“I HEREBY AUTHORIZE ANY PHYSICIAN, HEALTH CARE PRACTITIONER, HOSPITAL, CLINIC OR OTHER MEDICAL OR MEDICALLY RELATED FACILITY TO FURNISH ANY AND ALL RECORDS, MEDICAL HISTORY, AND SERVICES RENDERED OR TREATMENT GIVEN TO ME OR ANY DEPENDENT FOR PURPOSES OF REVIEW, INVESTIGATION OR EVALUATION OF ANY CLAIM SUBMITTED TO EMPIRE BLUE CROSS AND BLUE SHIELD.

I ALSO AUTHORIZE EMPIRE BLUE CROSS AND BLUE SHIELD TO DISCLOSE TO A HOSPITAL OR HEALTH CARE SERVICE PLAN, SELF-INSURER, OR AN INSURER ANY MEDICAL INFORMATION OBTAINED IF SUCH DISCLOSURE BE NECESSARY TO ALLOW THE PROCESSING OF THE CLAIM.

IF MY COVERAGE IS UNDER GROUP CONTRACT HELD BY AN EMPLOYER, AN ASSOCIATION, TRUST FUND, UNION OR SIMILIAR ENITY. THIS AUTHORIZATION ALSO PERMITS DISCLOSURE TO THEM FOR PURPOSES OF UTILIZATION REVIEW OR AUDIT.

THIS AUTHORIZATION SHALL BECOME EFFECTIVE IMMEDIATELY UPON EXECUTION AND SHALL REMAIN IN EFFECT FOR THE DURATION OF ANY CLAIM OR TERM OF COVERAGE WITH EMPIRE BLUE CROSS AND BLUE SHIELD INCLUDING A REASONABLE TIME THEREAFTER, UNTIL IT’S FINAL CONSUMMATION. THIS AUTHORIZATION SHALL BE BINDING UPON ME, MY DEPENDENTS, AND OUR HEIRS, EXECUTORS AND ADMINISTRATORS.”

MEDICARE PART B

“I REQUEST THAT PAYMENT OF ALL AUTHORIZED MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO THIS OFFICE FOR ANY SERVICES FURNISHED BY THAT PHYSICIAN TO ME. I AUTHORIZE ANY HOLDER FOR MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE CENTERS FOR MEDICARE AND MEDICAL SERVICES (CMS) AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMNE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.”

PATIENT (OR AUTHORIZED) NAME: ________________________________

PATIENT (OR AUTHORIZED) NAME: ________________________________

HEALTH INSURANCE CLAIM NUMBER (MEDICARE ID):________________

DATE: ____

PARENTAL CONSENT FORM

PATIENT NAME: ____

I AM AWARE MY CHILD IS RECEIVING PHYSICAL / OCCUPATIONAL THERAPY AT ONE ON ONE PHYSICAL THERAPY. I AM UNABLE TO ATTEND HIS / HER OFFICE VISITS. PLEASE ACCEPT THIS FORM AS MY CONSENT TO TREAT MY CHILD.

I AM AWARE I AM RESPONSIBLE TO PROVIDE YOU WITH THE CORRECT INSURANCE INFORMATION NEEDED TO PROCESS MY CHILDS BILLS. IF I FAIL TO DO SO, OR PROVIDE FALSE OR OUT OF DATE INFORMATION, I WILL BE HELD FINANCIALLY RESPONSIBLE.

PARENT / GUARDIANS SIGNATURE: ____________________________________

PRINT NAME OF PARENT / GUARDIAN: _________________________________

RELATIONSHIP TO CHILD: ______________________