river bend
PHYSICAL THERAPY & PREVENTATIVE CARE

Medical History

Name:_____

Age: _____ Height: _____ Weight: _____

What eases your pain? _____

What makes your pain worse? _____

What are your goals in physical therapy? _____

_____

Have you had previous treatment for this problem?

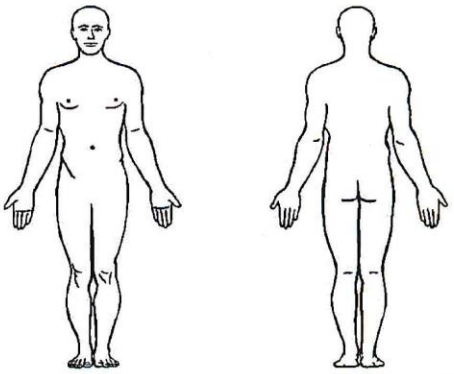
Please specify: PT _____ Chiropractic _____ Other _____

Have you had any of the following tests?

X-Ray:_____ CT Scan: _____ MRI: _____ EMG:_____

Please mark the areas of your pain here:

Pain (circle) Numbness /// Pin/Needles ... Shooting pain→



Please mark any of the following conditions that apply to you:

Allergies	Yes	No	Dizzy Spells	Yes	No	MRSA	Yes	No
Anemia			Emphysema/Bronchitis			Multiple Sclerosis		
Anxiety			Fibromyalgia			Muscular Disease		
Arthritis			Fractures			Osteoporosis		
Asthma			Gallbladder Problems			Parkinsons		
Autoimmune Disorder			Headaches			Rheumatoid Arthritis		
Cancer			Hearing Impairment			Seizures		
Cardiac Conditions			Hepatitis			Smoking		
Cardiac Pacemaker			High Cholesterol			Speech Problems		
Chemical Dependency			High/Low Blood Pressure			Strokes		
Circulation Problems			HIV/AIDS			Thyroid Disease		
Currently Pregnant			Incontinence			Tuberculosis		
Depression			Kidney Problems			Vision Problems		
Diabetes			Metal Implants					

Please explain any of the above marked "Yes" and describe any additional conditions or precautions:

Injury a result of a fall in the past year? Yes No Have you had two or more falls in the last year? Yes No

Please describe any previous **surgeries** or hospitalizations:

Surgery Type: Date (month and year):

Please list all **medications** you are currently taking:

Medication Dosage Frequency Route Reason Taking

Signature _____ Date: _____

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HOW DID YOU HEAR ABOUT OUR CLINIC: _____

FIRST NAME: _____MI: _____ LAST NAME: _____

MALE_____ FEMALE_____ DOB: _____ SS# _____

HOME PHONE: _____ CELLPHONE: _____

EMAIL ADDRESS: _____

ADDRESS:_____
Street Address & P.O. Box if Applicable City State Zip

EMPLOYER: _____ JOB TITLE:_____

EMPLOYMENT STATUS (Circle one): FT PT Retired Not Working Disability Self-Employed Homemaker Student

PRIMARY CARE PROVIDER: _____PHONE: _____

DATE OF (Circle One) INJURY / CONDITION / ACCIDENT : _____ DATE OF SURGERY: _____
EMERGENCY CONTACT: _____PHONE: _____RELATIONSHIP: _____

PRIMARY INSURANCE

WHAT IS YOUR PRIMARY HEALTH INSURANCE: _____

SUBSCRIBER'S NAME & RELATIONSHIP_____ _____

SUBSCRIBERS DOB_____ID#_____GROUP#_____

SECONDARY INSURANCE

WHAT IS YOUR SECONDARY HEALTH INSURANCE: _____

SUBSCRIBER'S NAME & RELATIONSHIP_____ _____
SUBSCRIBERS
DOB_____ID#_____GROUP#_____

IS YOUR INJURY JOB RELATED & DO YOU HAVE AN OPEN CLAIM? YES NO CLAIM # _____
EMPLOYER:_____CLAIMS MANAGER: _____ PHONE: _____
BILLING ADDRESS FOR SELF-INSURED COMPANIES: _____

IS YOUR INJURY DUE TO A MVA? YES NO THAT OCCURRED IN:_____ **STATE**_____

AUTO POLICY HOLDER: _____ CLAIM #_____ PIP
ADJUSTER: _____ PHONE: _____

PIP BILLING ADDRESS: _____

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FINANCIAL POLICY

Thank you for choosing River Bend Physical Therapy and Preventative Care as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment. All patients must complete our Information and Insurance form before seeing a therapist.

Payment Policy

We bill all contracted insurance carriers, however if you fail to bring your insurance information with you to your first appointment, payment will be required at the time of service. All co-pays are due at the time of service. Due to rising costs of billing by our facility, we now have the following options for payment of your bill: We accept cash, checks, VISA, MasterCard and Care Credit. We do understand that patients may experience financial problems occasionally. If you need to arrange a payment plan, please contact our Business Office

Regarding Insurance

We accept assignment of insurance benefits after your first visit. Our Financial Policy requires payment in full of any balance billed to you by our facility within 30 days of receiving a statement. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company and we are not a party to that contract. If your insurance company has not paid your account in full within 45 days, the balance may be automatically transferred to you. Please be aware that some of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance. You are responsible for providing any/all information sent to you by your insurance company as no return of this information will result in payment being delayed or denied, thereby becoming your responsibility

Regarding Insurance Plans where we are a participating provider: In the event that your insurance coverage changes to a plan where we are not participating providers, please refer to the above paragraph. In the instance that our fees go towards meeting your yearly deductible, this deductible amount will be billed to you and payable within 30 days of receipt of statement.

I hereby authorize my insurance company to make payment directly to River Bend Physical Therapy and Preventative Care for any benefits I may receive. I authorize the release of any information necessary to process my insurance claims, or facilitate payment of my account by a third party.

Medicare Physical and Occupation Therapy Limits

To our Medicare Patients: Effective January 1, 2011 Medicare has a cap of $1840.00 per calendar year for physical therapy and speech-language services combined. There is a separate yearly benefit limit of $1840.00 for outpatient occupational therapy. Medicare pays for Occupational, Physical, and speech therapy as long as it is medically necessary, but only up to the benefit limit of $1840.00. This is approximately 15 visits per calendar year. Medicare has an annual deductible of $162.00 and then pays at 80% with 20% being your responsibility, unless you have secondary insurance coverage.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Motor Vehicle Accidents

River Bend Physical Therapy is happy to evaluate and treat you for your motor vehicle related injury. We would like you to be aware that auto insurance companies cover physical therapy benefits as long as there is Personal Injury Protection (PIP) available on the claim. We do call on every claim to verify if PIP is available; however, the adjustor is unable to reveal the total dollar amount available. It is therefore, your responsibility as the patient to know and understand what benefits are covered. We will continue to bill your auto insurance until the PIP has expired and they deny any more payments. It is for this reason that we get a copy of your private medical insurance as a backup for billing services that may be denied. If you do not have private medical insurance the remaining balance will be your responsibility

Minor Patients

The adult accompanying a minor or the parents (or guardians of the minor) are responsible for full payment after insurance has paid their portion. For unaccompanied minors, physical therapy will be given only with the consent and signature of our Information and Financial Policy by the parent or custodial guardian. Co-pay arrangements will stand as referenced above. It may be necessary for the minor patient to call the responsible party for Visa or MasterCard information to process his/her co-pay before receiving treatment.

Missed appointments

Unless canceled, except for a genuine emergency, at least 24 hours in advance, we reserve the right to charge for missed appointments at the rate of **$25.00** per visit. If calling outside of business hours please leave a voice message stating your name, appointment date and time, and reason for cancelling. Please help us serve you better by keeping scheduled appointments.
Initials_____

Interest

We reserve the right to charge interest in the amount of 1.5% per month for each month payment is not received. If you have a remaining balance after 60 days your account may be placed for outside collection. In the event that fees are incurred with the collection of my account, I will pay such costs and fees, including collection agency fees, attorney fees and all court costs.

Email Disclosure

By providing River Bend Physical Therapy and Preventative Care with your email address, you are allowing us to share information with you about our company and services. We do not share email addresses with any third-party.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

I have read, understand and agree to the Financial Policy.

X _____ _____

Signature of Patient or Responsible Party **Date**