# WELCOME TO GERMANTOWN PHYSICAL THERAPY

## PATIENT INFORMATION

PATIENT NAME:_____
DATE OF BIRTH: _____ SEX: □ M □ F SOCIAL SECURITY #:_____
STREET ADDRESS: _____CITY: _____ STATE: _____ ZIP: _____
HOME PHONE: _____ WORK PHONE: _____ EXT: _____
ALTERNATE PHONE: _____ EMAIL ADDRESS:
_____

□ MARRIED □ SINGLE □ DIVORCED □ WIDOWED
PATIENT IS: □ EMPLOYED FT □ EMPLOYED PT □ RETIRED □ UNEMPLOYED
□ FT STUDENT □ PT STUDENT SCHOOL NAME: _____
PATIENT EMPLOYED BY: _____

## IF PATIENT IS A MINOR:

RESPONSIBLE PARTY NAME: _____
RELATIONSHIP TO PATIENT: □ PARENT □ GUARDIAN □ OTHER _____
TELEPHONE: _____ SOCIAL SECURITY #: _____

## PHYSICIAN INFORMATION

PLEASE LIST YOUR PRIMARY CARE PHYSICIAN AND TELEPHONE NUMBER
NAME: _____ TELEPHONE: _____
OTHER PHYSICIAN INVOLVED IN YOUR CARE AND TELEPHONE NUMBERS
NAME: _____ TELEPHONE: _____

## IN CASE OF EMERGENCY

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED?
NAME: _____ TELEPHONE: _____
RELATIONSHIP TO PATIENT: _____ ALT TELEPHONE: _____

## MEDICAL HISTORY

HAVE YOU HAD PHYSICAL THERAPY FOR THIS OR ANY OTHER CONDITION IN THE PAST YEAR? _____

CHECK IF YOU KNOW YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING…

| | | | | | |
|---|---|---|---|---|---|
| ALLERGIES | | EPILEPSY | | MULTIPLE SCLEROSIS | |
| ANEMIA | | FIBROMYALGIA | | PACEMAKER | |
| ASTHMA/BREATHING PROBLEMS | | GOUT | | RECENT WEIGHT LOSS | |
| BLADDER/BOWL PROBLEMS | | HEADACHES | | RHEUMATOID ARTHRITIS | |
| CANCER | | HEART/CIRCULATORY DISEASE | | SEIZURES | |
| CHRONIC FATIGUE SYNDROME | | HEPATITIS | | STEROID USE | |
| CURRENTLY PREGNANT | | HERNIA | | STROKE | |
| DENTAL PROBLEMS | | HIGH BLOOD PRESSURE | | SURGERIES | |
| DIABETES | | HIGH CHOLESTEROL | | THYROID PROBLEMS | |
| DIZZINESS | | HIV/AIDS | | OTHER | |

PLEASE EXPLAIN: _____

PLEASE LIST CURRENT MEDICATIONS AND THE CONDITION THEY ARE FOR: _____
_____

**Patient Name** _____

**Signature of Insured/Guardian** _____ **Date** _____

## PATIENT FINANCIAL AGREEMENT

**PATIENT NAME** _____

**W**e must emphasize that as medical providers, our relationship is with you. While the filing of insurance claims is a service that we extend to our patients, it is your responsibility to see that your charges are paid in full. Any known deductibles, co-pays, co-insurance, or non-covered services/supplies are due at the time of service**.** Any amounts rejected for any reason by your insurance company are due from you at the time of rejection. Payment can be made in the form of cash or check.

**A**ccounts unpaid are considered delinquent. Delinquent accounts will be referred to our attorney for collection, including court action. All costs incurred for collection are the responsibility of the patient, including attorney's fees.

**P**ayment is expected at the time of treatment for all deductibles, co-pays, and co-insurance**.** I understand and agree that I am financially/legally responsible for full payment of my bill for services and that any failure of my insurance carrier to pay for all or any part of my bill does not constitute a reason for me not to pay. I understand that my insurance policy is a contract between the carrier and myself, and that Germantown Physical Therapy is not responsible for settling disputed claims. Germantown Physical Therapy will provide the necessary information regarding my treatment in order to facilitate payment of my claim for benefits. Currently, the only form of payment accepted by Germantown Physical Therapy is cash or check. Any returned check will be charged a $25.00 service fee payable in cash within 10 days of notification.

**I** also understand that Germantown Physical Therapy requires 24 hours notice for cancellation of scheduled appointments and I (not my insurance carrier) may be financially responsible for late cancellations and missed appointments (no shows). Failure to do so will result in assessing a $30.00 charge payable by you, the patient, before further treatment is rendered.

**I** further agree that in the event my bill is referred for collection after a default, I will pay all costs of collection, court costs, and reasonable legal and attorney fees.

**I** hereby acknowledge that I have read this policy in its entirety and that I am responsible for my account. I have had all my questions concerning the financial policy answered and I fully understand the policy.

**I execute this POLICY as of the _____ day of _____, 2015.**

_____ _____

**Signature of Insured/Guardian** **Witness**

## ASSIGNMENT AND RELEASE

**I** hereby authorize ***Germantown Physical Therapy*** to furnish information necessary to secure payment of benefits to my insurance carrier (s) concerning my physical condition and treatments. I hereby assign ***Germantown Physical Therapy*** all medical benefits, if any, payable to me for services rendered to myself or my dependents. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ _____

**Signature of Insured/Guardian** **Date**

## PATIENT INFORMATION ACKNOWLEDGEMENT FORM

**I** have read and fully understand ***Germantown Physical Therapy's*** Notice of Information Practices. I understand that ***Germantown Physical Therapy*** may use or disclose any personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that ***Germantown Physical Therapy*** will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

**I** hereby consent to the use and disclosure of my personal health information for purposes as noted in ***Germantown Physical Therapy's*** Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____

**Patient Name**

_____

**Signature of Insured/Guardian**

_____

**Date**