Therapy Center

Patient Information Form

Patient Information

Last Name ______ First Name ______ MI ______ SSN ______

Address ______

Address2 ______ City ______ State ______ Zip ______

Home Phone ( ) - ______ Work Phone ( ) - ______ Cell Phone ______

Date of Birth ______ Gender ______ Marital Status ______ Email ______

Emergency Contact

Last Name ______ Relationship ______

First Name ______ Phone ( ) ______

Employer

Name ______ Phone ( ) - ______

Address ______

Address2 ______ City ______ State ______ Zip ______

Problem

Problem Description ______ Date of Injury ______ Last Physician Visit / / ______

Referred By ______ Primary Care Physician ______

Latest Referral Information ______ Motor Vehicle Accident ______

Latest Plan of Care ______ That occurred in: ______

Primary Insurance

Insurance ______ Deductible ______

ID ______ Max Benefit ______

Group # ______ CoPay ______ CoInsurance ______

Subscriber

Name ______

Relationship ______

Date of Birth ______

Secondary Insurance

Insurance ______ Deductible ______

ID ______ Max Benefit ______

Group # ______ CoPay ______ CoInsurance ______

Subscriber

Name ______

Relationship ______

Date of Birth ______

Tertiary Insurance

Insurance ______ Deductible ______

ID ______ Max Benefit ______

Group # ______ CoPay ______ CoInsurance ______

Subscriber

Name ______

Relationship ______

Date of Birth ______

I authorize payment and release of information requested by my insurance plan for payment.
I understand that I am financially responsible for any balance due.
I agree to allow said facility to evaluate and treat my condition and symptoms.

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices. This office utilizes a variety of measures to protect your identity and others..

Signature: ______ Date: ______

Date:

Last Name: First Name:

How did you hear about us? ___ *Facebook* __ *Website* ___ *Internet Search* ___ *Yellow pages*
__ *Newspaper* __ *Billboard* __ *Friend/relative/physician* ___ *I was a prior patient* ___ *Facility/Agency*
If applicable, Who can we thank for referring you to our office? ____________________

Employment Info: ****************************** __Not employed __Retired __Student
Name: ____ __Full-Time __Part Time
Address: ______________________________________
City: _____________________________________ State:______ Zip: _______________

Is your injury work related? Y / N *(Employer Info REQUIRED if work related!)*

Date of Injury? __________________

Is your injury the result of an accident? Y / N Auto / Liability *(circle one)*
If you are receiving care for injuries from an MVA, **what state did the accident occur in?** ____
Date of Injury? _________________
Do you have an attorney helping you? Name: ___________________
Phone:________________

Are you receiving any Home Health/Nursing Services? Y / N **Agency?**_________________
Hospice? Y / N **Agency?** _______________

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize the person(s) listed below to access my health information and/or make decisions, provide and/or request information on my behalf. I grant permission to handle any paperwork, payment info, scheduling appointments, and/or medical records.

______________________________ ________________________________

______________________________ ________________________________

Patient or Guardian Agreement

X *I agree to freely participate in evaluation, treatment, and re-evaluation as deemed necessary by the facility and/or practitioner. I authorize that the information I disclose to my therapist throughout the course of treatment is accurate to the best of my knowledge. I agree to notify Therapy Center at (337) 824-4547 within 24hrs. should any adverse reactions to treatment I received at this facility occur.*

X *I authorize release of information from other medical providers to **Therapy Center** by fax to **(337) 824-4548**.*

X *I authorize information obtained by this facility may be disclosed to other medical providers for collaboration or to insurance providers/ guarantors as requested in order for payment to be considered.*

Signature of Patient or Guardian: __________________________ ***Date*** ____/____/____

Are you CURRENTLY receiving any other Health Services:	**# Symptoms:**	**Activities of Daily Living**
☐Chemotherapy ☐Chiropractic ☐ Nursing Services through home health ________________ ☐ Nutritional/Dietetic Services ☐ Occupational Therapy ☐ Physician ☐ Psychology ☐ Radiation Therapy ☐ Speech Therapy ☐ Social Services ☐ Respiratory Therapy ☐ Hospice	☐Hypersensitivity ☐Numbness ☐Pain Rating ____ /10 0=no pain, 10= unbearable ☐Paresthesias ☐Poor Balance ☐Poor Endurance ☐Poor Stability ☐Vertigo ☐Weakness ☐Swelling **Other:**	***PRIOR** to this Episode/ Injury: I was able to perform all activities independently. I needed some help with ________________________ Dominant Hand: ☐Left ☐Right ***Caregivers:** ☐ I care for myself and others. ☐ I live alone and do everything without help. ☐ I get some help from others for ______________________________

AGE:_______**HEIGHT:**__________ **WEIGHT:**____________ Any significant change in past 12 months? ☐Yes ☐No

Do you use tobacco products? ☐Yes, Frequency?____ ☐No

Primary Limitation: Currently, I am unable to ____

Prior Surgeries, year performed: ____☐ No Prior Surgeries

Prior injuries:____☐ No Prior Injuries

Have you ever been diagnosed or treated for.. __ Arthritis/RA __ Balance issues __ Cancer __ COPD __Hepatitis __ cardiac conditions __ Diabetes __ epilepsy __ headaches/migraines __ hypertension __ neurological __TB

Do you have a pacemaker? _________ **Other:**

____

Is Pain aggravated by any certain activities or positions? ______________________________

Is your pain worse during a particular Time of the Day? __ Morning ___Mid-Day ___ Afternoon ____ Night

Do you experience any Sleep Disturbance: ☐No ☐Yes

Your expectation for therapy? ____

Your ability to attend therapy may be difficult due to ________________________________

Current Medications: Include all Prescriptions, over-the-counter, herbals, vitamins, minerals, dietary, or nutritional supplements

Name	Taken for:	Dosage	Frequency	Route Taken?
				_Oral _IV __injection __topical

LETTER OF PROTECTION

REQUIRED FOR ALL LIABILITY INJURIES

Patient Name: Patient DOB:

I, ______________________________, in consideration of Therapy Center providing physical/ occupational/ speech therapy treatment hereby authorize and direct my attorney or liability insurance to pay directly Therapy Center out of the proceeds resulting from any settlements, judgments, or verdict in or of my case or out of payment from any insurance company obligated to reimburse me for charges made for services rendered by Therapy Center a lien against the proceeds of any settlement, judgment, or verdict in or of my case for physical / occupational / speech therapy treatment provided to me by Therapy Center. arising out of injuries suffered on ____ - ____ - ____ .

I understand that I am directly responsible to Therapy Center for all professional bills submitted by Therapy Center for services rendered to me and that this agreement is made solely for Therapy Center's additional protection and in consideration of its awaiting payment. I also understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover moneys.

Furthermore, should I choose to retain different legal representation, I will notify Therapy Center within 10 (ten) days of such a change.

Signed: ______________________________ Date: ____________________
Patient's signature or legal guardian

The undersigned attorney hereby agrees to observe all of the terms of the above, and agrees to withhold from any settlement, judgment, verdict, or insurance payment such sums as are necessary to pay for the physical / occupational / speech therapy treatment provided by Therapy Center to the above named patient.

Signed: ______________________________ Date: ____________________
Attorney's Signature