

Promise physical therapy

Thank you for choosing Promise Physical Therapy for your rehabilitation. We trust that you will receive excellent care and service and that, as we work together, your goals will be achieved.

As with any other doctor's visit your insurance company will be billed for the services rendered at our facility. However, Physical Therapy falls under the major medical portion of your plan and, therefore, your major medical deductible will apply if not already met for the year. If you have any questions, please ask the front desk staff or an explanation.

PRIVACY ACT STATEMENT

Promise Physical Therapy's PRIVACY NOTICE is available for your review. If you would like a copy please ask our front office staff.

The new privacy act places significant restrictions on the availability of medical information. Violations of those restrictions carry fines and other penalties. Non-patients in treatment areas is a violation of the privacy rule. Please help us maintain integrity in this area of our practice.

All family member/visitors are to stay in the lobby and out of treatment areas.

APPOINTMENT POLICY

Patients must call at least TWO HOURS prior to your scheduled appointment time to cancel/ re-schedule. A \$20 'No-Show' Cancellation fee will be applied to all that do not call within the allotted time. (334) 358-2201

Thank you again for allowing Promise Physical Therapy to take care of your physical therapy needs.

By signing, you are agreeing to the above statements.

Patient's Name

Date

Signature:

ALL OF THE FOLLOWING PAGES ARE REQUIRED TO BE FILLED OUT COMPLETELY AND SIGNED ~ INCLUDING SOCIAL SECURITY NUMBER ~ IN ORDER FOR YOUR CHART TO BE COMPLETE. THANK YOU!

PROMISE PHYSICAL THERAPY
640 McQueen Smith Road North Prattville, AL 36066

******PATIENT INFORMATION******

NAME: _____ sex: M F DOB: _____ AGE: _____

ADDRESS: _____ social security # _____ - _____ - _____

CITY/ST/ZIP: _____ Marital Status: single married
divorced widowed

PHONE: home _____ cell _____ work _____

EMAIL ADDRESS: _____

EMERGENCY CONTACT: _____ phone: _____

PATIENT'S EMPLOYER/SCHOOL: _____ occupation: _____

NAME OF REFERRING DOCTOR: _____

Person responsible for account: _____

Relationship to patient: self parent spouse other DOB: ___/___/___ SSN: _____ - _____ - _____

Address: (if different than patient's) _____

City: _____ State: _____ Zip: _____ Phone: _____

Responsible party's employer: _____ Phone: _____

PRIMARY INSURANCE INFORMATION: WE WILL COPY YOUR INSURANCE CARD AND ID.

INSURANCE NAME _____

SUBSCRIBER'S NAME: _____ DOB: ___/___/___ SSN: _____ - _____ - _____

SUBSCRIBER'S EMPLOYER: _____

RELATIONSHIP TO PATIENT: self parent spouse other

CONTRACT # _____ GROUP # _____

SECONDARY INSURANCE INFORMATION:
INSURANCE NAME: _____

SUBSCRIBER'S NAME: _____ DOB: ___/___/___ SSN: _____ - _____ - _____

SUBSCRIBER'S EMPLOYER: _____

RELATIONSHIP TO PATIENT: self parent spouse other

CONTRACT # _____ GROUP # _____

*****ASSIGNMENT, RELEASE AND AUTHORIZATION FOR TREATMENT*****

Responsibility for PAYMENT, ASSIGNMENT OF BENEFITS, AUTHORIZATION AND MEDICAL RELEASE: I authorize release of any medical information needed to process my claim. I understand that I am responsible for any charges that are not covered by my insurance carrier. Furthermore, I understand that I am responsible to inform the office of any changes that occur. I authorize release of payment directly to Promise Physical Therapy regardless of participation in or out of network. Should I default on my financial responsibility and collection action is necessary, I will be responsible for collection costs that are incurred. I hereby agree and give my consent to medical treatment in treating my physical condition.

SIGNATURE OF RESPONSIBLE PARTY: _____ DATE: _____

Please refrain from wearing any perfume or lotion while attending physical therapy.

1. Is this an injury? **yes** **no**
2. If yes... Auto Work Comp. Other

Date of injury: _____

Date complaint/symptoms began: _____ Chief complaint with symptoms: _____

2. Have you had surgery for this injury/complaint? yes no

If yes...date _____ doctor _____

3. Have you had any diagnostic or rehabilitative services for this injury/complaint?

MRI X-Rays Other

If any of the above were checked, please list the facility at which they were performed. _____

4. Are you currently currently receiving or have you received Home Health care within the last 60 days?

YES NO

If YES, what dates did you receive services? _____

Name of the Home Health Agency: _____

5. Have you received Physical Therapy within this calendar year?

YES NO

If YES, list the name of the physical therapy facility:

Inpatient _____

Outpatient _____

*******Medical Release Form*******

The Health and Insurance Portability and Accountability Act of 1996 was developed to protect your personal information from being disclosed without your authorization. Effective April 14, 2003, we are required to have a release form signed by the patient before we can give out ANY medical or financial information to any person other than the patient.

Please list below the names, relationship and phone numbers of any authorized individuals that we may discuss your medical and/or financial accounts with:

Name	Relationship to Patient	Phone Number
1.		
2.		
3.		
4.		

May we leave medical information on your home answering machine? yes no
May we leave a voice mail on your cell phone? yes no

Signature: _____ Date: _____

If you do NOT want any of your medical or financial information discussed with anyone other than yourself, please sign below:

Signature: _____ Date: _____

ADVANCED BENEFICIARY NOTICE (ABN)-PART-B

NOTE: You need to make a choice about receiving these health care items. Insurance *does not* pay for all of your health care cost. The fact that insurance does not pay for a particular item or service does not mean that you do not need it. There may be a good reason your doctor or therapist recommended it.

The purpose of this form is to let you know that you may be responsible for these charges.
If you do not understand, we will be happy to explain. Thank you.

MEDICARE PATIENTS: The *only* fee that may apply is the Thera-Band.
WORKERS COMP: This notice *does not* apply to our workers comp patients.

ITEM...

*Thera-Band	\$ 5.00
*Iontophoresis (per visit fee)	\$ 7.00
*Electrode pads (one time fee)	\$ 8.00
*Photo Therapy (per visit fee)	\$10.00

I have read this notice and understand that if I choose to receive any of these items and my insurance company *does not* pay for them, *then I am responsible for the payment of these items.*

Patient's Signature: _____ Date: _____