

Atlantic Physical Therapy & Rehabilitation

Patient History

PLEASE COMPLETE ALL FORMS ATTACHED!

Patient name: _____ **Date of Birth:** _____ **Age:** _____

Street Address: _____ **City:** _____ **State:** _____ **Zip:** _____

E-Mail Address _____

Home Phone: _____ **Cell:** _____ **Social Security #:** _____

Gender: Male Female **Marital Status:** Single Married Divorced Widowed Other: _____

Ethnic origin: American Indian African American Caucasian Hispanic Eastern Indian Oriental/Asian

Employers name: _____ **Phone:** _____

Street Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Who to notify in an emergency?

Name: _____ **Relationship:** _____ **Phone:** _____

Is your injury a result of (circle): WORK, AUTO, OTHER **Date of Injury:** _____

Attorney Name/Phone/Address _____

Referring Physician: _____ **Primary Care Physician:** _____

Past Medical History

Major Surgical Procedures: _____

Medications: _____

PHYSICAL/OCCUPATIONAL OUTPATIENT THERAPY TREATMENT CONDITIONS

*Any reference to "clinic" is known as Atlantic Physical Therapy & Rehab and its employees

CONSENT TO TREATMENT

Any patient who is referred for treatment to our clinic is still under the supervision of his/her physician, as well as, the physical/occupational therapist for the treatment of his/her condition. The patient consents to any treatment necessary as prescribed by his/her physician. The patient recognizes that all therapists that consult and furnish services ordered by the referring physician are privileged to provide such services. We (Atlantic Physical Therapy & Rehab and its employees) are not liable if the patient does not follow the instructions of his/her attending physician/therapist during the course of outpatient therapy.

RELEASE OF INFORMATION

The clinic may disclose all or any part of the patient's medical record to any person or corporation that is liable for the clinic's charge including, but not limited to insurance companies, medical service companies, review agencies, workman's compensation carriers/attorneys, automobile insurance/attorneys, welfare funds and other government insurance companies. This release is strictly for reimbursement purposes to the clinic for services rendered.

The clinic may disclose all or any part of the patient's medical record for this admission to the referring physician, social worker, claims adjuster, treating physician, or family physician or other treatment agencies to aid in the continuing once discharged from the clinic.

Authorization must be signed by the patient or, in case of a minor or when a patient is physically or mentally incompetent by the nearest relative or legal guardian.

FINANCIAL AGREEMENT

The undersigned agrees to direct payment to the clinic of any insurance benefits otherwise payable to or on behalf of the patient for outpatient services rendered. In the event that your insurance plan or carrier does not reimburse the clinic for charges and associated expenses incurred by the patient or if the benefits under such insurance plans cease while the patient continues outpatient therapy the undersigned agrees to pay all charges and associated expenses not covered by those insurance plans for whatever period the patient continues outpatient treatment at the clinic. I understand that I am responsible for any/all amounts due that are not paid by my insurance company for any reason, along with any/all collection and legal fees incurred by this office in order to ensure payment on my account in full in a timely manner. I also hereby authorize Atlantic Physical Therapy and Rehab and all of its employees to furnish any necessary information to my insurance carriers/legal council concerning my treatment, and I hereby assign all payment for medical services rendered to myself or my dependents to the Clinic, Physical Therapist & Occupational Therapist. Payment plans can be arranged at the Clinic Business Office if deemed necessary. If your insurance plan changes or ceases during the course of treatment; it is **your responsibility** to notify the Business Office **immediately**.

I authorize the release of any medical information necessary to process insurance claims. **Payment is to be made directly to the clinic for service provided.** I understand I am responsible for any amount not covered by the insurance. I understand any bill unpaid after 30 days is outstanding and will be charged a rate of 1.5% per month and 18% per annum. Auto and Worker's Compensation have additional billing/financial agreements (see form for auto/wc).

MEDICARE AUTHORIZATION TO PERMIT PAYMENT OF MEDICARE BENEFITS

I certify that the information given by me in applying for payment under TitleXVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf I assign the benefits payable for services to the physician or Organization furnishing the services or authorize such physician or organization to submit claims on my behalf.

PATIENT RIGHTS AND RESPONSIBILITIES

A patient shall be fully informed of their rights and responsibilities and of all procedures governing patient conduct and responsibilities. The information will be provided to a patient by written via a copy at the time of admission. The undersigned acknowledges receipt of this information. When a patient is mentally retarded or incapacitated the signing must be signed by caretaker, legal guardian or witnessed by third party.

CANCELATION POLICY

I understand that I must give 24-hour notice, if not a \$25.00 fee may be applied to my account for prompt payment.

The undersigned certifies that he/she has read the above and fully completed all requested information. The undersigned has received copies thereof, and is the patient or is duly authorized by the patient as the patient's legal guardian/representative.

Patient/Legal Representative _____ Date _____