New Patient Intake Form

Date: _____ / _____ / _____

REFERRING PHYSICIAN: __________________________ **PRIMARY CARE PHYSICIAN:** _________________________
Patient's Name (print): ____ SSN#: _____ / _____ / _____
Mailing Address: ____
DOB: _____ / _____ / _____ Marital Status: _____________________ Circle one: MALE FEMALE
Telephone: Cell: _____ - _____ - _____ Home: _____ - _____ - _____ Work: _____ - _____ - _____
Primary Number: ____ Cell ____ Home ____ Work Receive appt. reminders via text ___ Yes ___ No
Email address: ____

Employer Name: ____________________________________ Phone Number: _____ - _____ - _____
Employer Address: ____
City: _________________________________ State: __________ Zip: _________________
Patient Occupation: ____

IN CASE OF EMERGENCY:
Notify: ________________________________ Phone: _____ - _____ - _____ Relationship: _____________________

Responsible Party Information
Circle One: Parent Spouse Guarantor Legal Guardian
Name: _______________________________ SSN#: _____ / _____ / _____ DOB: _____ / _____ / _____
Phone #: _____ - _____ - _____ Employer Name: ____
Employer Address: ____
City: _________________________________ State: __________ Zip: _________________

If you were a previous patient, when was your last visit with us? ______________________________

HOW DID YOU HEAR ABOUT US? Check one:
____ Physician Referral ____ Previous Patient ____ Friend/Family ____ Saw Sign ____ Newspaper/Online
Other: ____
If you heard of us via Family/Friend or Newspaper/Online please list who it was or what newspaper/online site it was: ____

Date of injury or when symptoms began: _____ / _____ / _____ Surgery Date: _____ / _____ / _____
What caused symptoms: ____
Condition related to: ___ Work ___ Auto ___ School ___ Other: Explain _____________________
City: _________________________________ State: __________ Zip: _________________
Date of last doctor's appt: _____ / _____ / _____ Next scheduled doctor's appt: _____ / _____ / _____

I hereby instruct the insurance company below to make payment to Lonoke Physical Therapy, Inc.
Primary Insurance: __________________________________ **Member #**: __________________________________
Policy Holder Name: ___________________________ Relationship: _______________ DOB: _____ / _____ /_____
Primary Insurance: __________________________________ **Member #**: __________________________________
Policy Holder Name: ___________________________ Relationship: _______________ DOB: _____ / _____ /_____

AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST

I request that payment of authorized insurance, a prepaid medical plan, Medicare or Medicaid benefits, for me or on my behalf, be made to Lonoke Physical Therapy, Inc. I authorize any holder of medical information about me to release to the insurance company and to the Health Care Financing Administration and its agents, any information needed to determine these benefits or the benefits payable for any charge covered by any insurance. I consent to therapy services as ordered by my physician and/or deemed necessary by a licensed therapist of Lonoke Physical Therapy, Inc.

Please sign and date:
Patient/Responsible Party: ____ Date: _____ / _____ / _____

Patient Medical History

Please check all that apply:

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

Describe any other conditions: ____
____
____

Describe any medical precautions: ____
____
____

Fall History

Have you had an injury as a result of a fall in the past year? ___ Yes ___ No

Have you had two or more falls in the past year? ___ Yes ___ No

Surgical History

Body Region: __________________ Surgery Type: ___________________ Date of Surgery: _____ / _____ / _____

Body Region: __________________ Surgery Type: ___________________ Date of Surgery: _____ / _____ / _____

Body Region: __________________ Surgery Type: ___________________ Date of Surgery: _____ / _____ / _____

Body Region: __________________ Surgery Type: ___________________ Date of Surgery: _____ / _____ / _____

Body Region: __________________ Surgery Type: ___________________ Date of Surgery: _____ / _____ / _____

Body Region: __________________ Surgery Type: ___________________ Date of Surgery: _____ / _____ / _____

Body Region: __________________ Surgery Type: ___________________ Date of Surgery: _____ / _____ / _____

Current Medications

Drug: ___________ Dosage: ________ Frequency: __________ Route: __________ Reason Taking: ____________

Drug: ___________ Dosage: ________ Frequency: __________ Route: __________ Reason Taking: ____________

Drug: ___________ Dosage: ________ Frequency: __________ Route: __________ Reason Taking: ____________

Drug: ___________ Dosage: ________ Frequency: __________ Route: __________ Reason Taking: ____________

Drug: ___________ Dosage: ________ Frequency: __________ Route: __________ Reason Taking: ____________

Drug: ___________ Dosage: ________ Frequency: __________ Route: __________ Reason Taking: ____________

Drug: ___________ Dosage: ________ Frequency: __________ Route: __________ Reason Taking: ____________

Cancel and No Show Policy

Dear Patient:

Throughout the course of your treatment it is extremely important that you are compliant with all your scheduled appointments to enhance your recovery and follow the treatment plan as prescribed by your physician.

Cancelled and No Show appointments severely impact your treatment plan as well as they prevent Lonoke Physical Therapy, Inc. from scheduling acutely ill patients who could have been seen that day, but were not because someone else scheduled for that time spot. No shows also drive up the cost of patient care for everyone as staffing and overhead cost for services go unused.

Due to an increasing problem with patients missing scheduled appointments or “No Shows,” we regrettably must institute a “**No Show Policy**.” We reserve the right to charge $25.00 for a missed appointment without a 24-hour notice. This charge is *not* covered by insurance. We understand emergencies do occur, and we ask that you please inform the front desk as soon as possible to make other arrangements prior to your scheduled time.

It is also important that you arrive on time for scheduled appointments to ensure quality of care as well as the care of others who are prompt.

Patient care is of utmost importance to the staff of Lonoke Physical Therapy, Inc. as evidenced by our past successes. We look forward to serving your needs, and please let us know if there is anything we can do to help!

Responsible Party Signature: _______________________________________ Date: _____ / _____ / _____

Financial Policy

TO OUR VALUED PATIENTS:

Payment for services is due on each visit for charges incurred up through your last visit. We accept cash, checks, MasterCard, Visa or Care Credit. We bill electronically, to expedite payment of claims. If you have an insurance that requires a paper claim to be completed, we will gladly complete and mail the claim form along with the claim for you.

Please read carefully:

1. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of U.C.R. "U.C.R." is defined as usual, customary and reasonable by most companies. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees, which bears no relationship to the current standard and cost of care in this area.

2. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. These particular services, if any, are your responsibility.

3. **Medicare patients without a secondary insurance are responsible for the 20% not covered by Medicare. You will also be responsible for any deductibles that are not covered by your secondary insurance.**

4. If this injury is work related, and a Workers Compensation claim has been initiated, you are given a certain number of authorized visits. We will need your Workers Compensation insurance billing information, your claim number, and case manager's name and phone number. In the event that Workers Compensation denies your case for any reason, then you are responsible for each additional visit. We require, on your initial visit, that you provide us with your medical insurance to insure payment of the account if your case is not allowed. If you already have a claim number, please provide us with the number on the registration form.

5. For liability cases, where another party is responsible, you must provide us with all the billing information. If you have an attorney, please provide this information on the registration form. It is this office's policy that our letter of protection must be signed and received from you and your attorney within the first 2 weeks of your treatment. Without this letter, you become responsible for the account in full. A lien will also be filed against you and released once the account is paid in full.

6. Payments made by check to Lonoke Physical Therapy, Inc. that are not honored by the bank will incur a returned check fee of $30.00. The payment will be reversed from the appropriate account when the bank returns the check.

Co-pays, deductibles, and private pay agreements are due at the time of service. We will accept this on a daily or weekly basis if you are scheduled more than one time a week. When paying weekly, we ask that they be paid on the first visit for that week. Your co-pays must be kept current each week unless other arrangements are made. Allowable forms of payment are cash, checks, Visa, MasterCard, or Care Credit. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

I request and authorize Lonoke Physical Therapy, Inc. to file my claim form for me. I authorize my insurance benefits to be paid directly to Lonoke Physical Therapy, Inc. I understand that I am responsible for any amount of my bill that is not covered by my insurance. If you have any questions about the above information or any uncertainty regarding insurance coverage, please don't hesitate to ask us. We are here to help you!

I have read and understand the above policies and agree.

Responsible Party Signature: _______________________________________ Date: _____ / _____ / _____

HIPAA Consent for Use and

I authorize Lonoke Physical Therapy, Inc. to use and disclose my health information as designated on this form.

This authorization for release of information covers the period of healthcare from all past, present and future periods. I authorize the release of my complete health record. This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

This authorization shall be in force and effect for 6 years, at which time this authorization expires. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

*A copy of the Notice of Privacy Practices is available upon request from the Care Coordinator.

________ Lonoke Physical Therapy, Inc. has authorization to leave a message on my answering machine.
Initial

List of Authorized Persons to access information:

Name	Relationship to patient	Phone
Name	Relationship to patient	Phone
Name	Relationship to patient	Phone
Name	Relationship to patient	Phone

Patient or Guardian (print): ________________________________ **Relationship to patient:** ___________

Patient or Guardian signature: ____________________________________ **Date:** _____ / _____ / _____

Account Information

At Lonoke Physical Therapy, Inc. we value you as a patient. In order to continue to provide exceptional service to all our patients, timely payment of your account is crucial. If you fail to pay your account in full within 90 days following your last office visit, we will refer your account to a collection agency. You shall be responsible for paying the fee that the collection agency charges for collection of your debt. The amount of that fee is 40% of your debt. That 40% will be added to your debt and collected by the collection agency. By signing below, you understand and agree to pay that fee. Also, please understand that you are responsible for any court costs or recovery costs associated with collection of your debt.

Should my account become overdue and subsequently transferred to a collection agency, I agree to pay a collection agency fee equal to 40% of my debt owed to your office *in addition* to the debt I owe. I understand that I am also responsible for any court costs or recovery costs associated with collection of this debt. I agree, in order for Lonoke Physical Therapy, Inc. to service my account or to collect any amounts I may owe, Lonoke Physical Therapy, Inc. or agents may call me at any telephone number associated with my account. Lonoke Physical Therapy, Inc. or agent may also communicate with me by sending text messages or e-mails. Methods of contacts may include using pre-recorded/artificial voice and/or the use of an automated dialing device. These authorizations shall remain in effect until individually withdrawn by you in writing to our facility and/or others to which authorization has been extended.

I have read this disclosure and agree that Lonoke Physical Therapy, Inc. or agents may contact me as described above.

Patient or Guardian signature: ______________________________________ **Date:** _____ / _____ / _____

Office Representative: ____ **Date:** _____ / _____ / _____

Media Release

This release form, if signed, will ***not*** be shared and will ***only*** be used for Lonoke Physical Therapy, Inc. purposes. Those purposes include, but are not limited to, our newsletters, advertisements, Facebook and website. The purpose of this Media Release Form is to ensure no one's photo, video or other medium is released without the patient's consent. Please check your preference below, then sign and date the form, where indicated.

_____ Agree   _____ Disagree

I, ______________________________________, (please print name) hereby give Lonoke Physical Therapy, Inc. permission to publish my name and/or photo in, but not limited to newsletters, ads, Facebook and website and any other marketing promotional pieces.

Patient or Guardian signature: _______________________________________ Date: _____ / _____ / _____