Marysville Physical Therapy

Please complete the entire form, including signatures and dates. Please ask if you have questions.

Patient Name: _____ Social Security #: _____
What name would you like us to use? _____ Birth Date: _____
Address: _____ Age: _____
City: _____State: _____ Zip: _____ Marital Status: S M W Other
Phones: Home_____ Cell _____ Work Phone: _____
Email address: _____ Sex: M or F

Employer or School: _____ Address: _____
Emergency Contact: _____ Relationship: _____ Phone: _____
How did you hear about us? _____

Referring Physician: _____ Phone: _____
Next appointment date with Referring Dr? _____ Surgery? Y or N When: _____
Primary Care Physician: _____ Phone: _____

Is this an Accident or Workers Compensation Claim? Y or N Injury Date: _____
Workers Comp Claim number: _____ Managed Care Co: _____
Adjuster Name: _____ Phone: _____
What is your primary auto insurance company's name? _____
Claim number: _____ Who was at Fault? _____
Adjuster Name: _____ Phone: _____
Have your physical therapy visits been approved by WC or the Responsible Insurance? Y or N

Have you had any type of therapy or chiropractic visits within the last 12 months? Y or N
What type and how many? _____ When: _____
What Facility or Office: _____
Orthotic Information: Height: _____ Weight: _____ Shoe Size: _____

If you do not have health insurance and wish to pay out-of-pocket, please **initial** the following:
I do NOT have health insurance. _____
I understand that MPT's self-pay charge per visit is $150.00 _____
I understand that this payment MUST be made AT THE TIME OF SERVICE, at each appointment. NO EXCEPTIONS. _____

PRIMARY INSURANCE NAME: _____
ID #: _____ Group #: _____Subscriber Name: _____
Subscriber Relationship to patient: _____ Subscriber DOB: _____
Subscriber Address: _____
Subscriber's Employer: _____Phone_____

SECONDARY INSURANCE NAME: _____
ID #: _____ Group #: _____Subscriber Name: _____
Subscriber Relationship to patient: _____ Subscriber DOB: _____
Subscriber Address: _____
Subscriber's Employer: _____Phone_____

I, the undersigned, do hereby **agree and give my consent** for Marysville Physical Therapy to furnish medical treatment to (please **PRINT** name) _____ that it is considered necessary and proper in diagnosing or treating his/her physical condition.

PLEASE COMPLETE SECOND PAGE

Therapist _____Acct #: _____Chart #: _____ ICD 10 _____

I, also hereby **assign all medical benefits** to include major medical benefits to which I am entitled, including Medicare, Medicaid, Private insurance and third party payers to Marysville Physical Therapy. A photocopy of the assignment is to be considered as valid as the original. I, hereby authorize Marysville Physical Therapy to release any information necessary, including Medical Records to secure payment.

Patient/Guardian Signature: _____ **Date:** _____

PATIENT AUTHORIZATION AND DISCLOSURE OF PROTECTED HEALTH IINFORMATION STATEMENT OF PRIVACY ACT (HIPPA)

We may disclose your health care information:

1. To other healthcare professionals within our practice for the purpose of treatment, payment, or healthcare operations.
2. To your insurance provider for the purpose of payment or healthcare operations.
3. To comply with State & Federal Workers' Compensation laws.
4. To public health employees for preventing/controlling disease and reporting infectious exposures.
5. In the course of any administrative of judicial proceeding or law enforcement purposes.
6. We **will not** release information to your physician under direct access unless you give us permission below.

Under HIPPA Federal Privacy law, you have the right to:

1. Request restrictions on certain uses of your health care information.
2. Inspect and copy your healthcare information.
3. Receive an accounting or disclosures of your protected health information made by us.
4. You have a right to a paper copy of our Privacy Practices at any time, upon request.
5. You have the right to refuse us the ability to release your information, which would make us unable to bill and collect from your insurance company. You would be responsible for payment.

We reserve the right to amend this notice of Privacy Practices at any time in the future. We are required by law to maintain the privacy of your healthcare information.

If you have any questions regarding this notice or if you want more information about your privacy rights, please contact Sherry Wood at 937-644-3311.

I would like to add the following people to have access to my information:

_____

My signature indicates **my authorization and consent** for Marysville Physical Therapy to use and disclose my protected health care information for the purposes of treatment, payment, and healthcare operations as described above.

Patient's Name (**PRINT**): _____
Patient/Guardian Signature: _____ **Date:** _____
Witness Signature: _____ Date: _____

I refuse to authorize Marysville Physical Therapy to use and disclose my private healthcare information for treatment, payment, and healthcare operations. I understand that with this refusal Marysville Physical Therapy may decline to treat me or those I am responsible for and that I am responsible for payment of all services. I have had full opportunity to read and consider the contents of this Authorization and the Notice of Privacy Practices.
Patient/Guardian Signature: _____ Date: _____
Witness Signature: _____ Date: _____

Reason for no signature: Individual refused to sign _____Communication barriers prohibited obtaining the authorization _____ An emergency situation prevented us from obtaining the authorization _____ Other (Please specify) _____
Witness Signature: _____ Date: _____