Pittman Physical Therapy, LLC

Patient Information Form

Patient Information

Last Name _____ First Name _____ MI _____

Address _____

Address2 _____ City _____ State _____ Zip _____

Home Phone ( ) - _____ Work Phone ( ) - _____ Cell Phone ( ) - _____

Date of Birth __/__/____ SSN ___ - ___ - ____ 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: _____

Notes: _____

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 release of information requested by my insurance plan for payment.
I understand that I am financially responsible for any balance due.
I agree to comply with the terms and conditions as outlined on the financial policy form.

I hereby acknowledge that I have been offered a copy of the Pittman Physical Therapy, LLC Notice of Privacy Practices.
The notice is also posted at the clinic.
(You have the right to refuse to sign this acknowledgement if you so choose.)

Signature: _____ Date: _____

NAME: _____ DATE: _____

REFERRING PHYSICIAN: _____ DATE OF BIRTH: _____

FAMILY PHYSICIAN: _____

MEDICAL HISTORY

Is your current condition related to an injury? **Yes____** **No____**

If YES, was the injury related to: **Auto____** **Work____** **Other____** **Date of Injury** _____

Are there any lawsuits pending regarding your condition? **Yes____** **No____**

Have you received physical/speech therapy in the last year? **Yes____** **No____**

If YES, refer to your insurance policy for limitations.

Please check any of the following conditions you have or may have had in the past:

_____ Heart Disease	_____ Tuberculosis	_____ Asthma
_____ High Blood Pressure	_____ Currently Pregnant	_____ Stroke
_____ Heart Murmur	_____ Fatique/Energy Loss	_____ C.O.P.D.
_____ Mood Disorders	_____ Chest Pain/Discomfort	_____ Hepatitis
_____ Shortness of Breath	_____ Ankle Swelling	_____ Anemia
_____ Kidney Disease	_____ Epilepsy/Seizures	_____ Diabetes
_____ Dizzy Spells	_____ Allergies	_____ Hernia
_____ Headaches	_____ Cancer: Type_____	
_____ Loss of Bladder/Bowel Control	_____ Other: _____	

ORTHOPEDIC LIMITATIONS

Please check any of the following conditions that you have or have had in the past:

_____ Osteoporosis	_____ Scoliosis
_____ Broken Bones	_____ Sprains/Strains
_____ Arthritis	_____ Balance/Walking Problems
_____ Fibromyalgia	_____ Limited Range of Motion
_____ Slipped/Ruptured Disc	_____ Subluxed/Dislocated Joints
_____ Weakness	_____ Painful Grinding/Cracking in a Joint
_____ Compression Fractures	

Have you had a recent: X-Ray____ MRI____ CT Scan____

If so, when? _____ _____ _____

Please list hospitalizations or surgeries you have had in the last five years, including dates:

_____

_____

Please list any medications you are currently taking:

_____

Are you allergic to any medications: Yes____ No____ If yes, please list: _____

Signature: _____ Date: _____

PT Signature: _____ Date: _____

MEDICARE QUESTIONNAIRE

Patient Name: _____ Date: _____

Social Security Number: _____

	(Circle One)	
1. Is this illness/injury covered by Workers' Compensation? If yes, note employer or insurer's name and address and claim number in #10.	Yes	No
2. Is this illness/injury covered under the Black Lung Program?	Yes	No
3. Are you entitled to benefits through the Department of Veterans Affairs (DVA)?	Yes	No
If yes, do you want the DVA to be contacted for authorization of these services?	Yes	No
4. Is this illness/injury the result of an auto accident? If yes, enter the responsible auto insurance/insured in #10.	Yes	No
5. Is another party's liability insurance responsible for this illness/injury? If yes, enter the responsible party's insurance in #10.	Yes	No
6. Are you covered by an Employer Group Health Plan (EGHP), including Federal Employee Health Benefits? If yes, enter the EGHP data in #10.	Yes	No
7. Are you or your spouse actively employed by an establishment of 20 or more employees? If yes, enter the EGHP data in #10.	Yes	No
8. Are you under age 65 and entitled to Medicare due to a disability? If no, move to #9.	Yes	No
If yes, are you or your spouse actively employed by an establishment of 100 or more employees (LGHP - Large Group Health Plan)? If yes, enter the LGHP data in #10	Yes	No
9. Are you entitled to Medicare solely on the basis of End Stage Renal Disease (ESRD)?	Yes	No
If yes, have you completed the ESRD coordination period? If no, enter the EGHP data in #10.	Yes	No

Complete the following information only if you answered "Yes" to one or more of questions 1-8, or "No" to answer 9b.

10. Name of Insurance Company:

Insured's Name and Policy Number:

Employer:

Insurer's Address:

Claim Number:

Pittman Physical Therapy, LLC Financial Policy

- Our practice accepts insurance from most insurance companies. As a courtesy, our practice will review your insurance coverage, estimate your insurance company payment, and file your claim with your insurance carrier.
- Your insurance coverage is a contract between you and your insurance carrier; however, we will assist you to maximize your insurance benefits.
- If your insurance does not remit payment within 60 days, the balance will be due in full from you.
- If an insurance problem occurs, you will be asked to assist us in contacting your insurance carrier. We feel it is necessary to work together to resolve any insurance problems.
- Returned checks and balances greater than 30 days may be subject to additional fees and interest charges of 1.5% per month. You will be responsible for any charges incurred due to collection proceedings, attorney's fees or court costs.
- Any money paid to you by your insurance company for services billed and rendered by Pittman Physical Therapy, LLC or any of its associates shall be paid to Pittman Physical Therapy, LLC immediately upon receipt. Failure to do so is illegal.
- You are responsible for any portion of your bill which is denied or not paid by your insurance carrier. This includes, but is not limited to, deductible, coinsurance and co-payments.
- I authorize payment of medical benefits from my insurance to Pittman Physical Therapy, LLC and the release of any medical information relating to all claims for benefits submitted on behalf of myself and/or dependents.
- I understand that I am responsible for all charges including those not covered by insurance. I understand my responsibilities as outlined in the Financial Policy.

Signature_____ Date_____

Pittman Physical Therapy, LLC Appointment Cancellation Policy

There is a $25 charge for missed or cancelled appointments without 24 hours notice.

(exceptions will be made for emergencies)

- We have reserved an allotted time for you which is now lost.
- We are unable to bill your insurance for this amount.
- If you have more than three "no shows" you will be discharged from therapy. We want you to get the maximum results from therapy and this means attending therapy on a regular basis.
- How would you like to be contacted for appointment reminders?
  ☐ Home Phone ☐ Cell Phone ☐ Work Phone

Signature_____ Date_____

Pittman
PHYSICAL THERAPY,LLC

622 West Poplar, Suite 5
Collierville, Tennessee 38017
PHONE: 901-850-5246 FAX: 901-850-5226

NOTICE OF PRIVACY PRACTICES / INFORMATION POLICIES

This notice describes how your health information may be used and disclosed and how you can access this information. Pittman Physical Therapy, LLC will always keep your health information secure and private.

Ways in which your confidential information may be used or disclosed without your authorization:

- The law permits us to disclose information to those involved in your treatment.
- We may disclose your information for billing purposes, gaining insurance or benefits information, insurance authorization and payment for services.
- Your healthcare information may be used during normal healthcare operations.
- We may use your information to contact you, to call to remind you of your appointments, for scheduling purposes or to inform you of insurance benefits. This may involve leaving messages on an answering machine or with the person who answers the phone.
- We may release some or all of your information when required by law.
- Your authorization is required to disclose your health information to other healthcare providers, individuals or third parties requesting information about you.

You have the right to:

- Know of any uses or disclosures we make with your health information beyond the above normal uses.
- Transfer copies of your information to another practice.
- See and receive a copy of your health information, with a few exceptions. Request must be in writing.
  (We may charge a reasonable copy fee.)
- Request that we amend your confidential information. Request must be in writing.
  (If we agree with the request, we will not alter the earlier document, but will add an addendum.)

Pittman Physical Therapy, L.L.C. will maintain the privacy of your confidential information as required by law and by the notice currently in effect.

If you feel that your rights have been violated, you may contact:
Department of Health and Human Services
200 Independence Avenue SW, Room 509F
Washington, DC 20201

You will not be penalized for filing a complaint. However, before filing a complaint or for assistance regarding the privacy of your health information, please contact Jeremy with Pittman Physical Therapy, LLC at 901-850-5246.

Patient's Signature:_____ Date: _____

We may leave a message on your answering machine or with any individual that may answer your telephone: YES_____ NO_____

Please name an individual or individuals with whom we may speak concerning your treatment in the event it should be necessary:

_____