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 BENEFTS, 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:**____________

1.Is this an injury? ____YES ____NO

If yes... ___Auto _____Work Comp. _____Other____

Date of injury: ________________

2. Date complaint/symptoms began: ____________________

3. Chief complaint with symptoms:

____

____

4. Have you had surgery for this injury/complaint? ___YES ___NO

If yes...Date: _____________ Doctor: ___________________________________

5. 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:

____

6. Within the last 60 days have you received:

HOME HEALTH CARE: ___YES___NO HOSPICE CARE: ____YES___NO

If YES, what dates did you receive services? _____________________________

Name of the Home Health Agency:___________________________________

Name of the Hospice Agency:_______________________________________

7. Have you received Inpatient or Outpatient Physical Therapy within this calendar year?

YES____NO_____

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

Inpatient ____

Outpatient____

Please date and sign below:

Please refrain from bringing family or friends into the gym.

This will allow our staff to provide exceptional care to each of our patients.

____

DO NOT WEAR ANY COLOGNE, PERFUME OR FRAGRANCE LOTION TO ANY OF YOUR PHYSICAL THERAPY APPOINTMENTS.

____

*Sign and Date:*___________________________________

***********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

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.

MEDICARE BENEFICIARY: These fees do not apply.

WORKERS COMPENSATION: These fees do not apply.

ITEM…

*Thera-Band	$ 5.00
*Electrode pads (one- time fee)	$ 8.00

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: _______________

MEDICATION LIST

Patient Name: ____

Please list all medications that you are currently taking, including dosage and frequency.

Please include any vitamins/supplements that you may be taking.

MEDICATION	DOSAGE	FREQUENCY

1.____

2.____

3.____

4.____

5.____

6.____

7.____

8.____

9.____

10.____

11.____

12.____

13.____

14.____

15.____

16.____

17.____

18.____

19.____

20.____