PRO THERAPY

PHYSICAL • OCCUPATIONAL • SPEECH

Appt Date: _____ Who referred you to Pro Therapy? _____

Time: _____ Was this the first you heard of us ? ___ Y ___ N

Therapist: _____ If no, where? _____

Initials & Date of Call: _____

Discipline requested ___ Physical Therapy ___ Occupational Therapy ___ Speech Therapy

PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____ SSN: _____

Address: _____
Street

_____ _____ _____
City State Zip

Sex: M ___ F ___

Marital Status: ___ Single ___ Widowed ___ Minor
___ Married ___ Separated ___ Divorced

Patient Employer / School: _____

Employer / School Address: _____

Responsible Party: _____

Relationship: _____

Employer Address: _____

_____

ACCIDENT INFORMATION

Is this condition due to an accident? ___ Yes ___ No

Date of Injury _____

Type of accident: ___ Auto ___ Work ___ Home ___ Other

Have you made a report of your accident? ___ Yes ___ No

Attorney Name: _____

Phone: _____

CONTACT INFORMATION

Home Phone: _____

Cell Phone: _____

Work Phone: _____

E-Mail Address: _____

Best time and place to reach you: _____

IN CASE OF EMERGENCY CONTACT

Name: _____

Relationship: _____

Home Phone: _____

Cell Phone _____

Work Phone: _____

REFERRING PHYSICIAN

Name: _____

Phone: _____

Fax: _____

Address: _____

_____

PRIMARY CARE PHYSICIAN

Name: _____

Phone: _____

Fax: _____

Address: _____

_____

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PATIENT CONDITION

Reason for visit: _____

When did your symptoms appear? _____

Is this condition getting progressively worse? __ Yes __ No __ Unknown

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of Pain:

___ Sharp ___ Dull ___ Throbbing ___ Numbness ___ Aching ___ Shooting

___ Burning ___ Tingling ___ Cramps ___ Stiffness ___ Swelling ___ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your:

___ Work ___ Sleep ___ Daily Routine ___ Recreation

Activities or movements that are painful to perform:

___ Sitting ___ Standing ___ Walking ___ Bending ___ Lying Down

Phone: (662) 282-4949
Fax: (662) 282-4955

3077 Highway 371 North
Mantachie, MS 38855

PRO THERAPY
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PATIENT'S PRIMARY INSURANCE

Primary Insurance: _____ Secondary: _____

Patients Name: _____

Policy Holder: _____ _____

Name Relationship DOB

Policy Holder's Employer: _____ Policy Holder's SSN: _____

Policy ID Number: _____ Group Number: _____

Covered Amount: _____ / _____ % CoPay:$ _____ Deduct:$ _____ Deduct Met? _____

Referral Req? _____ Pre-Auth/Pre-Cert Req? _____ Effective Date of Policy: _____

Pre-Auth/Pre-Cert Phone: _____ Pre-Auth/Pre-Cert Fax: _____

Max # Visits: _____ #Visits used/History on file: _____

Has Pt. had home health: _____ Start Date: _____ End Date: _____

Is Aquatic Therapy Covered? (97113) _____

Any Policy Exclusions/Restrictions? _____

Insurance Person Contacted: _____ Contacted By: _____

Employee Date

MAIL CLAIMS TO: _____

NOTES: _____

I HAVE READ THE INSURANCE VERIFICATION AND I UNDERSTAND THESE BENEFITS ARE NOT GUARANTEED. THE ABOVE IS AN ESTIMATE FOR MY INSURANCE COMPANY. MY CO-PAYMENTS AND % OF RESPONSIBILITY IS DUE AT THE TIME I AM TREATED. IF I OWN MORE THAN THE INSURANCE COMPANY ORIGINALLY QUOTED, I WILL BE RESPONSIBLE FOR THAT AMOUNT. IF I OVER-PAY MY BILL, I WILL BE REIMBURSED THE AMOUNT I OVERPAID ONCE I AM FINANCIALLY DISCHARGED. I HAVE RECEIVED A COPY OF THIS VERIFICATION FORM.

Patient Signature: _____

Date: _____

Practice Representative: _____

Date: _____

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HEALTH HISTORY FORM

What treatment have you already received for your condition? Medications Surgery Physical Therapy Chiropractic Services
None Other_____

Name and address of other doctor(s) who have treated you for your condition_____

Date of last: Physical Exam_____ Spinal X-ray_____ Blood Test_____
Spinal Exam_____ Chest X-ray_____ Urine Test_____
Dental X-ray_____ MRI, CT-Scan, Bone Scan_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	YES	NO	Diabetes	YES	NO	Liver Disease	YES	NO	Rheumatic Fever	YES	NO				
Alcoholism	YES	NO	Emphysema	YES	NO	Measles	YES	NO	Scarlet Fever	YES	NO				
Allergy Shots	YES	NO	Epilepsy	YES	NO	Migraine Headaches	YES	NO	STD	YES	NO	Anorexia	YES	NO	
Glaucoma	YES	NO	Mononucleosis	YES	NO	Stroke	YES	NO	Appendicitis	YES	NO	Goiter	YES	NO	
Multiple Sclerosis	YES	NO	Suicide Attempt	YES	NO	Arthritis	YES	NO	Gonorrhea	YES	NO	Mumps	YES	NO	
Thyroid Problems	YES	NO	Asthma	YES	NO	Gout	YES	NO	Osteoporosis	YES	NO				
Tonsillitis	YES	NO	Bleeding Disorders	YES	NO	Heart Disease	YES	NO	Pacemaker	YES	NO	Tuberculosis	YES	NO	
Breast Lump	YES	NO	Hepatitis	YES	NO	Parkinson's Disease	YES	NO	Tumors; Growths	YES	NO	Bronchitis	YES	NO	
Hernia	YES	NO	Pinched Nerve	YES	NO	Typhoid Fever	YES	NO	Bulimia	YES	NO	Herniated Disk	YES	NO	
Pneumonia	YES	NO	Ulcers	YES	NO	Cancer	YES	NO	Herpes	YES	NO	Polio	YES	NO	
Vaginal Infections	YES	NO	Cataracts	YES	NO	High Blood Pressure	YES	NO	Prostate Problem	YES	NO	Whooping Cough	YES	NO	
Chemical Dependency	YES	NO				High Cholesterol	YES	NO	Psychiatric Care	YES	NO	Other:_____			
Chicken Pox	YES	NO	Kidney Disease	YES	NO	Rheumatoid Arthritis	YES	NO				_____			

EXERCISE
None
Moderate
Daily
Heavy

WORK ACTIVITY
Sitting
Standing
Light Labor
Heavy Labor

HABITS
Smoking Packs/Day_____
Alcohol Drinks/Week_____
Coffee/Caffeine DrinksCups/Day_____
High Stress Level Reason_____

Are you Pregnant? YES NO Due Date_____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
Pharmacy Name_____		
Pharmacy Phone:_____		

OTHER INFORMATION

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Fax: (662) 282-4955
3077 Highway 371 North
Mantachie, MS 38855
Get Moving. Stay Moving.
www.protherapyms.com

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize Pro Therapy, LLC., to obtain my Protected Health Information including, but not limited to, History and physical exam, lab reports, progress notes, X-Ray reports, substance abuse (including alcohol/drug abuse), Mental Health (including psychotherapy notes), HIV related information (including AIDS related testing).

I understand that this authorization will expire 365 days from the date I have signed this form and that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified, except to the extent action has already been taken in reliance upon it. I also understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.

PRIVACY NOTICE

By my signature below, I acknowledge that I have received a copy of this practice's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law and understand my rights as a patient regarding my personal health information.

TREATMENT COMMITMENT

Pro Therapy cares very much about each person we treat. We are committing to you, our patient, to deliver Exceptional Care, with Exceptional Results! We request of you, our patient, a commitment to help us deliver what we promise, by understanding what is required of you. You play a large role in your health by the actions you choose to take. Listed are some of your responsibilities as a patient at PT:

1. Attending, on time, all scheduled appointments.
2. Informing your therapist of your progress, each visit.
3. Compliance with your treatment plan developed by your therapist.
4. Asking questions when you do not understand any instructions given to you by our staff.
5. Notifying your therapist in advance of your next doctor's appointment.

PATIENT MISSED APPOINTMENT POLICY

We strive to provide our patients with the utmost professionalism and excellence of service. Our commitment to your well-being and gain of your abilities is something every one in our clinic takes quite seriously. Your adherence to the recommended number of treatments is a vital component of your progress with our services; therefore we have certain rules that need to be followed in order to ensure the most optimum results.

In an instance of cancellation, without 24 hours notice, we reserve the right to charge you a $25.00 fee. In an instance of a no-show you will be charged a $50.00 fee. After the second no-show or third cancelled appointment all future appointments will be removed from the schedule and you will be added to our "same day appointment only" list.

In instances of repeated non-compliance with your scheduled visits, we also reserve the right to discontinue care and will inform your physician of the fact that your service has been discontinued due to non-compliance with the prescribed rehabilitation order.

We appreciate you greatly as our patient and strive to accomplish wonderful results and success for you.

By signing, Patient agrees & understands all items outlined above

_____ _____

Signature of Insured/Patient Date

_____ _____

Practice Representative Date

FINANCIAL POLICY

We are committed to providing you with the best in Therapy care. In order to do this without compromising our patients; this policy has been implemented for each patient. If you have medical insurance, we are anxious to assist you in receiving your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy.

Payment for services is due at the time services are rendered unless other acceptable and agreed upon arrangements have been approved in advance by our staff. We accept cash, checks, Visa, MasterCard and Discover. We will be accommodating to you in the process of seeking reimbursement from your Insurance carrier. In special instances we may accept assignment of insurance benefits.

Deductibles and Co-payments must be made at each visit. It is our policy to collect a percentage of each visit or the entire fee until a deductible has been reached.

Please be further advised that Returned checks and balances older than 30 days from your Treatment discharge may be subject to additional collection and legal fees, as well as, interest charges of 1.6% per month.

If you participate with our in network groups such as MEDICARE, BCBS, MEDICAID, UHC, and ACCLAIM, we will bill your insurance company and accept assignment of benefits. You will be responsible for any co-pays or deductibles at each visit. We will verify your coverage and determine your out-of pocket cost prior to Treatment starting. We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company.
2. 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.
3. Not all services and diagnosis codes are a covered benefit in all insurance contracts.
4. We will not COMPRISE patient care based on an insurance companies “FEE SCHEDULE”.
5. Verification of your insurance benefits is not a guarantee that payment will be made.

In cases involving Auto Claims and Worker’s Compensation, we will ONLY accept payment directly from the patient or from their insurance company and will arrange to accept payments from attorneys on a case by case basis. If a patient has instructed their insurance company to send payment to their attorney, the patient will be billed and held solely responsible and accountable for their bill. We will accept settlements on auto accounts only after prior approval and a letter of protection is on file.

We must emphasize that as a Medical provider, our relationship is with you, not your insurance company. While the filing of an insurance claim is a courtesy that we extend to our patients, all charges are your responsibility from the date the services were rendered. 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.

If you have any questions about the above policy or any uncertainty regarding your insurance coverage, PLEASE don’t hesitate to ask us. WE ARE HERE TO HELP YOU!

_____ _____

Patient’s Signature/Insured Date

_____ _____

Practice Representative Date

ASSIGNMENT OF MEDICAL BENEFITS, PAYMENT RESPONSIBILITY AND AUTHORIZATION FOR TREATMENT

PATIENT: _____

1. THE UNDERSIGNED, hereby authorize Pro Therapy, LLC and its affiliates ("Provider") to render to Patient physical therapy, occupational therapy, speech therapy or other related services (collectively, "Therapy Services") that Provider or Patient's treating physician determines may be necessary or advisable. Patient agrees to cooperate with all reasonable requests by Provider in connection with Provider's rendition of Therapy Services.
2. THE UNDERSIGNED, hereby certify that all information provided to Provider by the undersigned or Patient, including any information in connection with applying for a payment under Title XVIII of the Social Security Act, is true and accurate in all respects.
3. THE UNDERSIGNED, hereby authorize Provider to disclose any information, furnished to Provider or obtained by provider in connection with Patient's treatment (including information concerning a related Medicare claim), to any physician, governmental agency (including the Social Security Administration or any of its intermediaries or carriers), insurance company or health care facility requesting such information.
4. THE UNDERSIGNED, hereby assign to Provider all Medicare benefits and Medicaid benefits to which Patient may be entitled for any Therapy Services rendered by Provider. The undersigned hereby authorize and direct Provider to apply and file for all such benefits on behalf of Patient. In the event Patient is covered by both Medicare and Medicaid, Patient's Medicare deductible and any applicable Medicare co-payment will be covered by Medicaid. The undersigned acknowledge that Provider has disclosed to the undersigned that Provider is a supplemental Medicaid provider and that Provider is paid directly by Medicaid. In addition, the undersigned approves contact with the appropriate family members for medical claims management purposes.
5. THE UNDERSIGNED, hereby assign to Provider all private medical insurance benefits (primary and secondary, including med. Gap providers) or other benefits to which Patient may be entitled for any Therapy Services rendered by Provider. The undersigned hereby authorize and direct provider to apply and file for all such benefits on behalf of Patient.
6. THE UNDERSIGNED, authorizes Pro Therapy to deposit checks received on Patient's account when made out to the patient or signed over by the patient when Insurance Company pays against services provided.
7. THE UNDERSIGNED, agree that the undersigned shall be jointly and severally financially responsible for any portion of Provider's invoice that is not paid, except in the event of Medicare denial or Medicaid eligible recipients. The undersigned warrant and represent to Provider that Patient is not a member of, or covered by, a health maintenance organization or similar arrangement. The undersigned shall be liable to Provider for all services rendered by Provider in the event Patient is covered by a health maintenance organization or similar arrangement.
8. THE UNDERSIGNED and patient agree to execute any documents and perform any acts that Provider may reasonably request. The undersigned warrant and represent that attached hereto are originals or certified copies of any applicable powers of attorney, health care surrogate forms or court orders appointing the undersigned as the legal guardian of Patient.
9. THE UNDERSIGNED, agree that the provisions hereof shall continue in full force and effect until Provider has received written notice of termination signed by the undersigned; provided, however, that the provision of paragraphs 2, 4, 5, and 6 shall survive any such termination.
10. THE UNDERSIGNED, acknowledge that Provider has disclosed to the undersigned that no physician owns any interest to Provider.
11. THE UNDERSIGNED understands that they have a choice or rehabilitation service providers.

_____ _____
Patient's Signature/Legal Representative/Insured Party Date

_____ _____
Practice Representative Date