Spencer County Physical Therapy Patient Information

Injury Date _____ Surgery Date _____

What Body Part(s) are we seeing you for? _____

Patient's Name _____ DOB _____Age_____SS#_____

Street Address _____City _____ Zip _____

PO Box # _____City _____ Zip _____ Home Phone_____

Cell Phone _____ Employer _____ Work Phone _____

Referring Doctor _____ Family Doctor _____

Email Address: _____

Emergency Contact: _____ Relation _____Phone_____

Information about the policy holder (Person whose name is on the initial policy, not a dependent on the policy)

How are you related to the policy holder? Self Spouse/Sig. Other Parent Guardian

Policy Holder's Name: ___ _____ DOB _____ SS# _____

Policy Holder's Home Phone _____ Work Phone _____ Cell Phone _____

Past Medical: **Circle** every item that applies to the patient.

Diabetes – Insulin / Meds		Any Heart Problems / High BP		Use an inhaler / C-pap machine	
Cancer / Skin Cancer		Pacemaker / Use Nitroglycerin		History of Seizures / Epilepsy	
Lung / Breathing Problems		Ever had a stroke (CVA)		Sensitivity to Heat or Ice	
Latex Allergy / Sensitive Skin		Osteoporosis (thin bones)		Pregnant – Now	
MRI or CT (this problem)		Any Contagious Disease (now)		Had surgery (this problem)	

Please list any PRESCRIPTION medication you are currently taking:

1._____ 2._____ 3._____

4._____ 5._____ 6._____

I give my consent for an evaluation and treatment at Spencer County Physical Therapy (SCPT). I also assign all major medical benefits to SCPT. A photocopy of this assignment is considered as valid as the original. I authorize SCPT to release all information necessary, including medical records, to secure payment. I was given the opportunity to read SCPT's Privacy Notice Summary and offered a copy for my records. The full document is available in the waiting room. ***Initials*** _____

It is your responsibility to know your insurance benefits and to provide us with a copy of your current insurance card. You are ultimately responsible for the entire bill. If your insurance company, including but not limited to Medicare, Medicaid, private, third party, Auto and Worker's Compensation, does not remit payment within 90 days, or denies the claim, the balance will be due in full from you. Any unpaid balance, 30 days after you receive a bill from SCPT, will incur 2% monthly interest plus the full cost of all collection and attorney fees. Copayment, deductible, and/or co-insurance payment is required prior to treatment (at check-in). Returned check fee is $30. In the event my Worker's Compensation or Auto Claim is denied, I give authorization to bill my health insurance and agree to pay any balance due, including but not limited to, my deductible, co-payments and co-insurance. ***Initials*** _____

All equipment, except TENS units, is solely owned by SCPT and profit from sales of any product is income for SCPT. You are under no obligation to purchase any product. If you are unable to keep a scheduled appointment, you must call us to cancel. If you do not call prior to your appointment time, you (not your insurance company) will be charged $25.00 per occurrence. I agree to pay this fee. ***Initials*** _____

How did you hear about us? (Circle all that apply**):** Your Doctor Previous Patient Web Search
Family / Friend Sign on Building Phone Book Newspaper Facebook

I have read the above information, or it has been explained to me. I understand all of my financial responsibilities and agree to accept and pay for physical therapy services as prescribed by agents of SCPT.

_____ _____ _____
Signature Date MR# (Office use only) Rev. 8-2017