Spencer County Physical Therapy Patient Information

Injury date ___________________________________ Surgery Date ____

What Body Part we are seeing you for? ____

Patient Name ____________________________________ DOB ________ Age _____ SS# _______________________

Street Address _______________________________________City ______________________________ Zip _________

PO Box # _________ City _____________________________________ Zip ___________ Home Ph _______________

Cell Phone ________________ Employer ______________________________________ Work Ph ______________

Referring Doctor ________________________________ Family Doctor _______________________________________

Emergency Contact: ___________________________ Relation _________________________Phone__________________

Information about the policy holder (person who pays the insurance premium)

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

Policy Holder's Name: ____________________________ DOB: ______________ SS# ______________________________

Policy Holder's Home Phone______________________ Work Ph _____________________Cell Ph______________________

Past medical: Check all that apply to you (patient). If more than one item is in the box, circle which one applies to you.

Diabetes – Insulin / Meds		Any Heart Problems		Use an inhaler	
Cancer / Skin Cancer		Do you have a pacemaker		History of Seizures / Epilepsy	
Lung / Breathing problems		Ever had a stroke (CVA)		Sensitivity to Heat / Ice	
Latex allergy		Osteoporosis (thin bones)		Pregnant – Now	
Had an MRI (this problem)		Had a CT Scan (this problem)		Had surgery (this problem)	

Please list any **PRESCRIPTION** medication you are **currently taking**

1.______________________________ **2.**________________________________ **3.** ____________________________

4.______________________________ **5.**________________________________ **6.** ____________________________

7.______________________________ **8.**________________________________ **9.** ____________________________

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? (Check all that apply): _____ Doctor _____ Previous Patient
_____ Family / Friend _____ Sign on Building _____ Phone Book _____ Newspaper

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. 1-2016