PATIENT NAME

Legal Last Name: _____ Legal First Name: _____ Middle: _____

If Minor: Parent/Guardian Legal Name:_____

PATIENT DEMOGRAPHICS

Gender: (circle one) **M / F** Birth date: _____ Employer: _____

SS#_____ Marital Status: _____

Street Address: _____ City:_____

State: _____ Zip: _____ Email: _____

☐ HOME
☐ CELL
☐ WORK_____

☐ HOME
☐ CELL
☐ WORK_____

Emergency Contact:_____Phone:_____

INSURANCE INFORMATION

Insurance Company:_____ Policy Holder's Name: _____

Policy Holder's Date of Birth _____Policy #:_____

PATIENT HISTORY & PHYSICAL

Current sports / activities: _____

What are you being seen for?: _____

Current medications: _____

List any previous orthopedic surgeries and dates:_____

_____

Do you have a Do Not Resuscitate (DNR)? (circle one) **Y / N** Are you pregnant?: (circle one) **Y / N** Age: _____

Do you suffer from any of the following? (check all that apply)

☐Asthma ☐HIV ☐Diabetes ☐Skin conditions:_____
☐Multiple Sclerosis ☐Lupus ☐ Arthritis ☐Contagious Diseases: _____
☐Other:_____

PATIENT HISTORY & PHYSICAL CONT.

Have you previously had any of the following? (check all that apply)

☐Physical Therapy ☐Chiropractic ☐Massage ☐Acupuncture

What are your goals concerning your condition? _____
_____

REFERRING PHYSICIAN (if applicable)

Physician: _____Phone:_____

INJURY INFORMATION (if applicable)

Injury Date: _____ Surgery Date:_____ Auto: (circle one) **Y / N** Workers Compensation: (circle one) **Y / N**

Claim Information: _____

Adjuster Name: _____Phone #_____Fax:_____

AUTHORIZATION FOR RELEASE OF INFORMATION

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to each person/entity.
☐**Spouse (provide name & phone #)** _____	☐Financial ☐Medical
☐**Parent (provide name & phone #)** _____	☐Financial ☐Medical

HOW DID YOU HEAR ABOUT US?

☐Search Engine ☐Social Media ☐At an Event

Referred by a Current Patient? Who?_____

Other: _____

To the best of my knowledge, this information is correct: (Sign) _____

THANK YOU FOR CHOOSING ONE80 PT!

Financial Policy

The following is the One 80 Physical Therapy, P.C. financial policy. We require that you read and sign this prior to treatment. Please do not hesitate to ask any questions.

Upon your first visit, we will ask for your complete insurance information, **a copy of your insurance card, and a copy of your photo ID (drivers license).** Your **policy is an agreement between you and your insurance provider. We will do our best to help you determine the benefits of your plan, but it is your responsibility to fully understand your individual contract.** Our charges are based on the treatment provided and on our professional judgment. Each charge has a predetermined dollar amount that reflects services rendered.

We are an in network provider with most major insurance companies and we will follow the guidelines of your in network insurance plan. For those companies that we are an **out of network provider** we will bill your insurance directly for the full amount of your treatment. If your plan has a deductible, you will be responsible for paying charges until that amount is met. If your insurance company covers a portion of your visit, you will be responsible for payment of your portion. You may pay with cash, check, or credit card. **Payment is due at the time of treatment**.

We are a participating provider for Medicare. Medicare will require a physician's referral for physical therapy before they reimburse for your treatments. Medicare will pay 80% of the charges at this clinic until your yearly cap is met. Most secondary insurances will pay the remaining 20% of your charges. If you do not have secondary coverage, you will be responsible for the remaining 20%. You are also responsible for paying any deductible and/or any charges incurred after your yearly cap has been met.

If your account becomes delinquent, collection proceedings will occur and you will be charged a collection fee of $50.00 for each month that you have a balance in collections. If your case goes to court, you will be responsible for any attorney fees and / or court costs incurred.

Adults must accompany minors (anyone under 18 years of age) for the first visit in order to give consent to treat, and are also responsible for payment of services during the duration of care.

Please cancel appointments 24 hours in advance. We reserve the right to charge $30.00 for each appointment cancelled without proper notice. Failure to show or cancel an appointments is $65.

I hereby authorize direct medical payment for physical therapy services to One 80 Physical Therapy, P.C. I have read and understand the above financial policy. I will assume any financial responsibility for fees not covered by my insurance plan, collections fees, and / or cancellation fees as outlined above. My signature below authorizes this office to release medical information to my insurance provider and any collection agency in order to assist with any outstanding balances on my account.

_____ _____

Responsible Party Signature **Date**

Privacy Policy

One 80 Physical Therapy, P.C. understands that your privacy needs to be protected. During the course of your treatment, we will be collecting personal information. All information that we collect will be confidential. If you wish to read our HIPAA Notice of Privacy Practice, it has been provided at the front desk. By signing below, I acknowledge that I have been given access to such documentation.

_____ _____

Responsible Party Signature **Date**