Patient Information Form

Full Name ____
Last First Middle

Mailing Address

____
Street City State Zip

Phone ____
Home Cell Work

DOB _____________ Sex ___ **Social Security No**. ___________________________

Email _____________________

WOULD YOU LIKE TO RECEIVE OUR MONTHLY EMAIL NEWSLETTER? Yes No Thanks

Do you wish to receive appointment reminders by: Please circle **TEXT EMAIL NO THANKS**

Are you currently receiving any **Home Health Services**? (Aide, Nursing, Therapy) ? Yes No

Have you had any outpatient Physical Therapy this year? Yes No

Do you give Revive PT permission to leave message concerning treatment on your answering machine? Yes No

Family Physician _____________________ Referring Physician (if different)_________

Emergency Contact ____
Name Phone Relationship

If patient is a minor ____
Guardian's Name Address Phone

Employer ___________________

Primary Insurance Information

Policyholder's name ____

Policyholder's employer ____

Date of birth _____________ Relationship to patient ______________________________

Policyholder's Social Security No. ______________________________

Name of Primary Insurance Carrier ______________________________

Phone No. Insurance Carrier ______________________________

Policy # ___________________________________ Group# ____________________________________

Send Claims to: ____

Consent for Care & Treatment

I, ______________________________, hereby give my consent to Revive Physical Therapy, Inc. to furnish physical therapy as considered necessary and proper for evaluation and treatment.

Benefit Assignment and Release of Information

I hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare and contracted Private Insurances to Revive Physical Therapy, Inc. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize Revive Physical Therapy to release all information necessary, including medical records to secure payment.

Information Policy: Revive Physical Therapy Inc. will use and disclose your personal health information to treat you, to receive payment for the care provided to you and for other health care operations. Health care operations include but not limited to those activities we perform to improve the quality of care. We have a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always have copies of the current notice for distribution at our facility.

Designated Individuals

I hereby authorize the following parties to receive any protected health information regarding treatment, payment, or administrative operations related to treatment and payment. I understand that the identity of these parties must be verified before the release of any information. I also understand that these parties may be contacted in case of emergency.

Name: _____________________________________ Phone: ____________________________

Name: _____________________________________ Phone: ____________________________

Financial Policy Statement

WE BILL YOUR INSURANCE CARRIER SOLELY AS A COURTESY TO YOU, IF YOUR INSURANCE DENIES PAYMENT FOR ANY REASON, YOU MAY BE RESPONSIBLE FOR THE ENTIRE BILL. You will be responsible for all co-payments, co-insurance percentage, and/or unmet deductibles at the time of services are rendered. In the event your insurance carrier requests a refund of payments made for any reason, you will be responsible for total monies refunded to your insurance company. If any payments are made directly to you for services billed by us, you recognize an obligation to promptly submit payment to Revive Physical Therapy, Inc.

ESTIMATED INSURANCE BENEFITS AND PATIENT RESPONSIBILITY:

____

____

Late / No Show Policy

We ask that you please call within 24 hrs to cancel or reschedule appointments. If you are more that 15 min late you may be asked to reschedule.

I have read and understand the above information and understand that all claims final determination and approval is at the discretion of my insurance carrier, and that I am responsible for any amount left to patient responsibility once a claim has been reviewed and processed through my carrier.

I understand and agree that if I fail to make any payments for which I am responsible in a timely manner, I will be responsible for the cost of collection of all monies owed, including but not limited to: court cost, collection agency fees, and attorney fees.

When paying by check I acknowledge and accept that if my check is dishonored or returned for any reason, I will be responsible for all bank fees, and the full amount of the returned check along with a reprocessing fee of $25.00.

By signing below, I agree to all the above, give consent for care and treatment, and claims filing to my insurance carrier on my behalf.

Patient and/or Legal Guardian Signature: ____

Today's Date: ______________________ **Office Witness:** ___________________________________

Medical History

Existing or Relevant Previous Conditions

Condition	Response	Condition	Response	Condition	Response
Allergies	◯ Yes ◯ No	Dizzy Spells	◯ Yes ◯ No	MRSA	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Emphysema/Bronchitis	◯ Yes ◯ No	Multiple Sclerosis	◯ Yes ◯ No
Anxiety	◯ Yes ◯ No	Fibromyalgia	◯ Yes ◯ No	Muscular Disease	◯ Yes ◯ No
Arthritis	◯ Yes ◯ No	Fractures	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Gallbladder Problems	◯ Yes ◯ No	Parkinsons	◯ Yes ◯ No
Autoimmune Disorder	◯ Yes ◯ No	Headaches	◯ Yes ◯ No	Rheumatoid Arthritis	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Hearing Impairment	◯ Yes ◯ No	Seizures	◯ Yes ◯ No
Cardiac Conditions	◯ Yes ◯ No	Hepatitis	◯ Yes ◯ No	Smoking	◯ Yes ◯ No
Cardiac Pacemaker	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Speech Problems	◯ Yes ◯ No
Chemical Dependency	◯ Yes ◯ No	High/Low Blood Pressure	◯ Yes ◯ No	Strokes	◯ Yes ◯ No
Circulation Problems	◯ Yes ◯ No	HIV/AIDS	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Currently Pregnant	◯ Yes ◯ No	Incontinence	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Depression	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Vision Problems	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Metal Implants	◯ Yes ◯ No		

Describe any other conditions

If "Yes" to Any of the above, please explain and give approximate dates/Describe any other Conditions

Fall History

Injury as a result of a fall in the past year? ◯ Yes ◯ No

Two or more falls in the last year? ◯ Yes ◯ No

Patient is at risk for falls? ◯ Yes ◯ No

Surgical History

Body Region: ____________________ Surgery Type: ______________________ Date: _____________, ______, _________

Body Region: ____________________ Surgery Type: ______________________ Date: _____________, ______, _________

Body Region: ____________________ Surgery Type: ______________________ Date: _____________, ______, _________

Body Region: ____________________ Surgery Type: ______________________ Date: _____________, ______, _________

Current Medications

Drug: ______________ Dosage: ______ Frequency: __________ Route: __________ Reason Taking: ____________________

Drug: ______________ Dosage: ______ Frequency: __________ Route: __________ Reason Taking: ____________________

Drug: ______________ Dosage: ______ Frequency: __________ Route: __________ Reason Taking: ____________________

Drug: ______________ Dosage: ______ Frequency: __________ Route: __________ Reason Taking: ____________________

☐ **Currently not taking any medications**