NEW PATIENT FORM

PLEASE PRINT CLEARLY

Date:_____

Name (Last) _____ (First) _____ (M.I.) _____

Birth Date_____ Social Security_____ Age _____Sex: M / F

Home Address_____

City_____ State_____ ZIP_____

Disorder to be treated_____ Date First Consulted_____ Past Therapist_____

Cell Phone (_____)_____ Home Phone (_____)_____Work Phone (_____)_____

Email _____ How shall we contact you? (circle) Cell Ph./ Home Ph./ Work Ph./ Email

Status Married/Single/Divorced/Separated/ Widowed **Student** No/ Full-time / Part-time

Employment Full / Part-time / Not Working / Retired **Employer**_____

Emergency Contact_____Relation_____ Phone_____

Referring Physician_____ Telephone _____

How did you hear about us? ☐ Friend/Relative _____☐ Internet ☐ Yelp ☐ Facebook ☐ Physician ☐ Other_____

Injury Type ☐ Work ☐ Auto ☐ Home ☐ Other_____ Is an attorney involved? Yes / No

Attorney name _____

Address _____ Telephone # (_____) _____

Patient Signature:_____Date:_____

(OFFICE USE ONLY) 12/18/13

Primary Insurance_____

Insured Name_____Social Sec#_____D.O.B._____

Relation to Patient Spouse / Child / Other

Secondary Insurance_____

Insured Name_____Social Sec#_____D.O.B._____

Relation to Patient Spouse/ Child / Other

Referring Dr. Address _____ UPIN # _____

Speech Disorder(s) Being Treated: _____

Financial Class: CASH BCBS MEDICARE CIGNA COMMERCIAL INSURANCE

MEDICAL HISTORY

Patient Name_____ Age_____

Type of Disorder/Injury/ Condition _____

Injury Date_____

Type of Surgery & Date _____

Next Doctor's Appointment _____

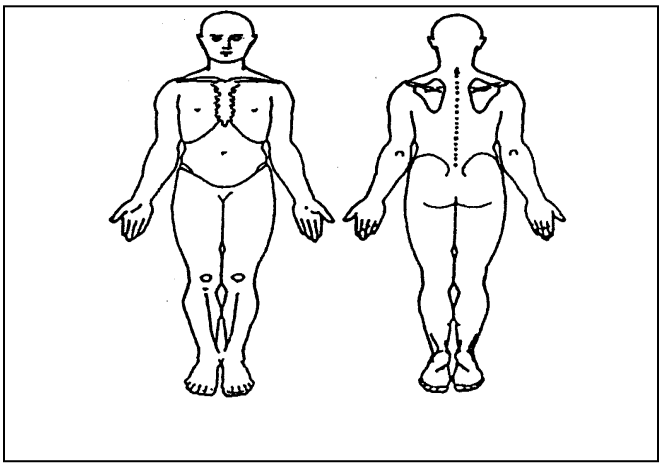
Describe previous treatment for this condition_____

_____

Have you received speech therapy treatment this year? Yes / No

Have you received physical therapy treatment this year? Yes / No

Have you received Home Health Care via Medicare this year? Yes / No



Please mark the area(s) of concern

Have you had any imaging performed?

- ☐ X-Ray
- ☐ CT Scan
- ☐ MRI
- ☐ Doppler
- ☐ Ultrasound

Have you recently noted any of the following? :

- ☐ Weight Loss /Gain
- ☐ Weakness
- ☐ Pregnant / IUD
- ☐ Pain at Night
- ☐ Nausea / Vomiting
- ☐ Fever / Chills / Sweats
- ☐ Headaches
- ☐ Cramps in Legs When Walking
- ☐ Fatigue
- ☐ Numbness / Tingling
- ☐ Change In Vision or Hearing
- ☐ Insomnia

Do you have now or have you ever had any of the following?

- ☐ Surgeries
- ☐ Sprains / Strains
- ☐ Heart Problems
- ☐ Circulation Problems / Clots
- ☐ Easy Bruising / Bleeding
- ☐ Indigestion / Heartburn
- ☐ Loss of Consciousness
- ☐ Diabetes
- ☐ Cancer
- ☐ Asthma / Breathing Problems
- ☐ Leg / Ankle Swelling
- ☐ Fainting
- ☐ Fractures
- ☐ Blood Pressure Problems
- ☐ Motor Vehicle Accident
- ☐ Lung Disease
- ☐ Urinary Problems / Infections
- ☐ Allergies / Skin Sensitivity
- ☐ Any previous injury that may affect current care _____

Please explain & give approximate dates for any items indicated above_____

_____

Are you currently taking medications? Yes / No Name or Type of Medication _____

_____

Type of Pain: Sharp / Burning / Aching / Tingling / Numbness / Other _____

Rate your pain (1=minimal 10=severe): At its worst: 1 2 3 4 5 6 7 8 9 10 / At its best: 1 2 3 4 5 6 7 8 9 10

What do you hope to get out of your treatment?_____

_____

What are your physical or fitness goals?_____

_____

Is there anything else you would like to include or ask your physical/speech therapist?_____

Patient Signature **Date**

OFFICE POLICY

CONSENT FOR TREATMENT OF A MINOR: As parent and/or legal guardian, I authorize **Bellaire Health & Rehabilitation** to treat the minor patient named in the attached forms while I am not present.

CONSENT FOR CARE & TREATMENT: Your Physical Therapist will complete an evaluation by examination and interview. Your individual treatment program will then be designed. A variety of treatment techniques may be used. I the undersigned do hereby agree and give my consent for **Bellaire Health & Rehabilitation** to furnish physical and/or speech therapy care and treatment considered necessary and proper in evaluating or treating my physical condition.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize **Bellaire Health & Rehabilitation** to furnish information to insurance carriers concerning this treatment and I hereby assign all payment for services rendered.

WORKERS' COMPENSATION CLAIMS: If you claim Workers' Comp benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered.

CANCELLATION & NO-SHOW POLICY: We require 24 hours notice in the event of a cancellation. The charge for cancellation without proper notice is $50 for a speech therapy visit. This charge will not be covered by insurance, but will have to be paid by you personally, prior to receiving additional treatment.

_____

Patient/Guardian/Responsible Party **Date**

FINANCIAL POLICY: We bill your personal insurance carrier solely as a courtesy to you. You are responsible for your bill. Per the contractual obligations, we have with your insurance company, we are required to collect all payments at the time of treatment unless payment arrangements are made prior to your treatments. If your insurance carrier does not remit payment to us within 60 days, the balance owed will be due in full from you. In the event that your insurance company requests a refund of payments made to us, you may be responsible for the amount of money refunded to your insurance company. If any payment is made directly to you by the insurance company for services billed by us, you recognize an obligation to promptly remit the payment(s) to us. If formal collections procedures become necessary, you will be responsible for additional costs incurred. Your insurance benefits as quoted to us by your insurance carrier have been reviewed with you. We assume no liability for any errors made by your insurance carrier in this quotation. We have reviewed these benefits with you and you agree to pay your portion of this bill.

Co-Pay	Co-Insurance
Estimated Co-Pay $_____/visit Deductible $_____/year **___Will pay each visit** **___ Will pay weekly in advance**	**Estimated** Co-Insurance $_____/visit Deductible $_____/year **___Will pay portion of deductible each visit** **___ Will pay Co-Insurance each visit**

The above Financial information has been read and explained to me. I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

_____

Patient/Guardian/Responsible Party **Date**

_____

Clinic Representative **Date**

24 HOUR CANCELLATION POLICY

To Our Patients Regarding Cancellations and No Shows:

When you do not attend as scheduled, three people are being hurt by the action: 1) you--because you did not receive your treatment as prescribed; 2) the therapist—who scheduled the time for you, and your treatment; 3) another patient who could have been scheduled if proper notice was given.

The following are our policies regarding cancellations and no-shows. We take this subject seriously at the clinic, because it can make the difference between whether or not you succeed in your treatment. You referring doctor or Therapist has prescribed a frequency of treatment and maintaining your scheduled visits is your highest priority.

- We require a 24-hour notice in the event of a cancellation. It is your responsibility, when you call, to have an alternate time in mind that will ensure you attend the entire number of prescribed treatments for each week.
- There is a $50 charge for a cancellation without proper notice. This charge is NOT covered by your insurance and will have to be paid by you personally. Even if it is a last minute cancelation, we greatly appreciate you notifying us so we can attempt to schedule our waiting list patients in your space.
- For worker's compensation and personal injury patients, documentation of any missed appointments will be forwarded to your Case Manager, and Primary Physician and this can jeopardize your claim.

In an instance of a cancellation without 24 hours notice, or No-Show to a scheduled appointment, we reserve the right to charge a $50 fee.

1. After the 1st offense a credit card number will be requested, if not already on file, to collect the **$50** fee.
2. After the 2nd offense the fee will increase to our standard cash rate of **$100** and will remain for all subsequent infractions.
3. Cancellation and No-Show fees are to be paid prior to the following appointment. You may not be able to be treated until fees are paid.
4. In addition, 3 offenses without payment may result in the loss of your physical therapy benefits. We reserve the right to cancel all future appointments and withhold scheduling future appointments.

_____ (Patient Initial) _____(Staff Initial)

Please co-operate with our Cancellation and No-Show policy; it benefits all. We are looking forward to working with you!

_____ _____

Patient (Guardian) Signature: Date:

HIPAA POLICY

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR THE PURPOSES SET FORTH WITHIN THIS AUTHORIZATION

_____ _____

Signature of Patient or Representative Date

_____

Patient's Name

_____

Date of Birth

_____

Social Security Number

_____ _____

Name of Personal Representative (if applicable) Relationship to Patient

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A copy of the completed and signed Authorization form has been provided to the patient or representative:

_____Yes _____No

_____ _____

Signature of Authorized Clinic Representative Date