Patient Information Form

Patient information *

Last Name_____First Name_____MI_____

Address_____Apt_____

City_____State_____Zip_____

Home Phone_____Cell Phone_____Work Phone_____

Date of Birth_____ SSN_____ Gender_____ Marital Status_____

Email_____

Employer

Name_____Phone_____

Address_____

City_____State_____Zip_____

Emergency Contact *

Last Name_____First Name_____MI_____

Relationship_____Home Phone_____Cell Phone_____

Problem *

Major Complaint_____When did it start_____

Motor Vehicle Accident Yes___ No___ Date of Accident_____State Occurred_____

Open Auto Claim Yes_____No_____ Claim # _____

Work Place Injury Yes_____No_____ Date of Injury_____

Open Work Comp Claim Yes_____No_____Claim # _____

Referring Physician *

Name_____Phone_____

Primary Care Physician *

Name_____Phone_____

Primary Insurance

Insurance_____ID_____

Subscriber Name_____Date of Birth_____

Secondary Insurance

Insurance_____ID_____

Subscriber Name_____Date of Birth_____

Tertiary Insurance

Insurance_____ID_____

Subscriber Name_____Date of Birth_____

Disputes regarding benefits are between the patient and the insurance company. Notification of changes to insurance is the responsibility of the patient. All charges are ultimately the responsibility of the patient.

My representative or I, recognizing the need for care, consent to all services ordered or deemed appropriate by my physician and/or physical therapist.

Signature*:_____ Date*: _____

FINANCIAL POLICY

Insurance

With the ever-changing world of health care, we want to do our best to educate our patients on their specific insurance benefits and any possible financial obligations. We must emphasize that as a medical provider, our relationship is with you not your insurance company.

The following is a statement of our Financial Policy and your agreement to follow our policy, which we require you to read and sign prior to your evaluation or treatment. Our front desk will verify your insurance benefits and submit claims to your insurance company as a courtesy to you. However, it is your responsibility to know your co-payments, co-insurance, deductible, coverage and limits as we are not responsible for any incorrect information your carrier had relayed to us.

Once we have verified your insurance information, our front office staff will give you an ***estimate*** of how much each visit will be and if you have a visit limitation. Our charges vary depending on the complexity of the diagnosis, the amount of procedures needed for your treatment, and the time required for your therapy sessions. Our practice is committed to providing the best treatment possible for our patients, and our charges are what is usual and customary for our area.

It is very important to notify the front desk of any change in your insurance policy. This will make sure that you are not held responsible for any outstanding insurance balance if there are untimely filing issues or limitations in your therapy benefits. We will be happy to verify this new insurance for you.

If you have accrued a balance of over **$100**, some form of payment is due at the time of service. If you are having difficulty with this payment, please talk with the billing manager regarding this matter **before** you decide to cancel future appointments. Unpaid balances over **60** days will be charged a **$18** late fee. Returned checks will be subject to **$30** collection charge.

Appointments and Attendance

For treatment to be effective and covered by insurance, it is important for you to be treated consistently. If you are unable to attend an appointment, please call us **at least 24 hours** in advance to reschedule. This will allow us to give your appointment to another patient. There will be a **$25.00** service charge for if the cancellation occurs less than 24 hours of your appointment as it makes it difficult for us to fill that spot with other patients wanting in. If you do not call us to cancel and you do not show up, there will be a **$50.00** no-show charge. We appreciate your communication if you cannot make your appointment so that we can make sure to get another person in that needs treatment.

Missing more than 3 scheduled appointments without advance notice may result in being put on "same day status". Meaning, you can still schedule your appointments but only on the day of. However, after attending 3 consecutive appointments, you can be removed from "same day status" and begin scheduling your appointments for weeks in advance.

Authorization to Release and Assign Insurance Benefits: I authorize release of any information required to act on any insurance claim and permit photographic or other facsimile reproduction of this authorization to be used in place of the original assignment. I hereby assign to Modern Physical Therapy the medical benefits I am entitled from my insurance company and/or Medicare.

I hereby acknowledge and agree to the Financial Policy above. I will adhere to the cancellation and no-show policy.

_____ _____

Patient's Signature * **(Or Authorized Signature)** **Date** *

_____ _____

Printed Name of Patient **Relationship to patient**

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures
Treatment Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations Your health information may be used as necessary to support the day-to-day activities and management of **the medical practice for Modern Physical Therapy.** For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Additional Uses of Information Appointment reminders: Your health information will be used by our staff to send you appointment reminders.

Information about treatments: Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and service that we believe may interest you.

Individual Rights
You have certain rights under the federal privacy standards. These include:

- the right to request restrictions on the use and disclosure of your protected health information
- the right to receive confidential communications concerning your medical condition and treatment
- the right to inspect and copy your protected health information
- the right to amend or submit corrections to your protected health information
- the right to receive an accounting of how and to whom your protected health information has been disclosed
- the right to receive a printed copy of this notice

Modern Physical Therapy Duties
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice
.

Right to Revise Privacy Practices
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information
As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our office.

Complaints
If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Modern Physical Therapy
335 NW Barry Road
Kansas City, MO 64155

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person
The name of the person you can contact for further information concerning our privacy practices is:

Office Manager
Lisa Aulner

I have received or been offered and declined a copy of Modern Physical Therapy's Privacy Practices. I have had the opportunity to have any questions answered regarding the privacy practices of the clinic.

_____ _____

Patient's Signature * (Or Authorized Signature) **Date ***

_____ _____

Printed Name of Patient **Relationship to patient if not patient**

How Did You Hear About Us?

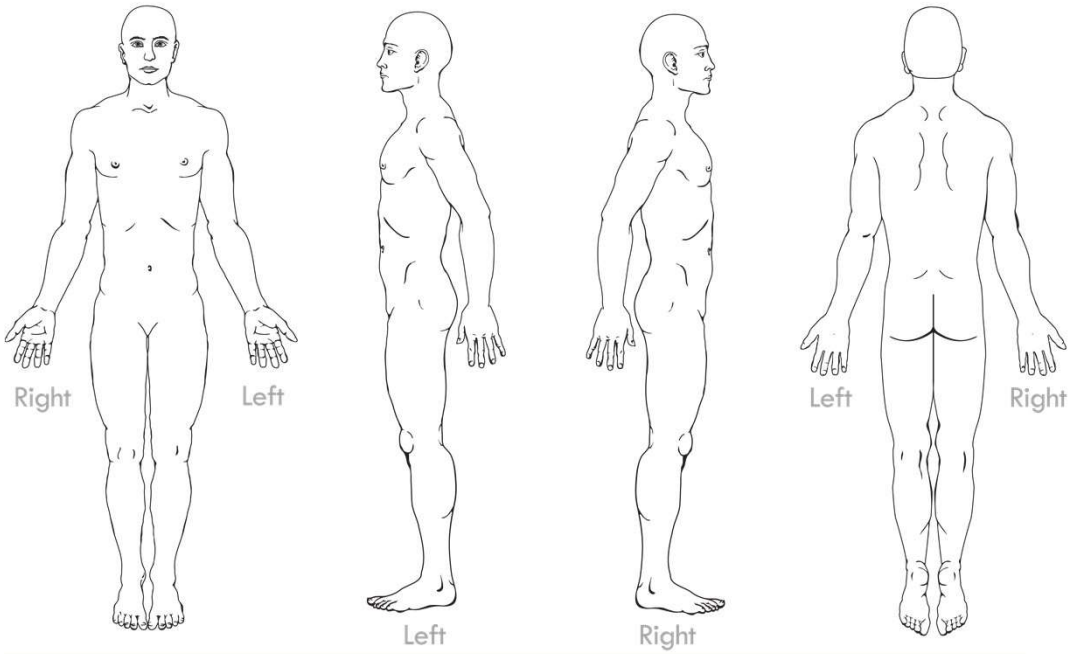
(check all that apply)

- ☐ Physician Specifically Sent you to MPT
- ☐ Physician: nonspecific
- ☐ Family:_____
- ☐ Friend:_____
- ☐ Treated Here Before
- ☐ Google/Internet
- ☐ Noticed Clinic from Road
- ☐ Close to Home
- ☐ Planet Fitness Ad
- ☐ Health Insurance
- ☐ Other: _____

MODERN PHYSICAL THERAPY

Name:_____ Date: _____

Please fill in your area(s) of discomfort / symptoms, drawing as specific as you can.



YOUR PAIN: (Please indicate your level of pain by circling a number from 0 to 10)

0/10: No Pain 1-3/10: Minimal Pain 4-6/10: Moderate Pain 7-9/10 Severe Pain 10/10: Need to go to the ER

My current pain is	0	1	2	3	4	5	6	7	8	9	10
My least amount of pain over last week	0	1	2	3	4	5	6	7	8	9	10
My worst amount of pain over last week	0	1	2	3	4	5	6	7	8	9	10
My average amount of pain over last week	0	1	2	3	4	5	6	7	8	9	10

Yes No

Do you have times where you are pain free?

What percent of the time are you pain free?_____%

Pain is: Not changing Getting better Getting worse

What activities are limited or increase your symptoms? _____

_____

_____

What movements/activities help to relieve your symptoms? _____

_____

_____

At the present time, would you say that your health is: Excellent Very Good Good Fair Poor

MEDICAL HISTORY FORM

For a thorough and complete evaluation, please provide us with this important background information. If you do not understand a question please ask your therapist.

Are you latex sensitive? Yes No

Please circle any of the following whose care you are under:

Medical doctor	Pain Physician	Surgeon
Osteopath	Chiropractor	Neurologist
Psychiatrist/Psychologist	Physical Therapist	Other: _____

Tobacco use: How many packs do you smoke per day_____, for how many years?_____

If you quit when? _____

Have you EVER been diagnosed with the following conditions?

Y / N	Cancer	If YES, what kind? _____	Y / N	Asthma
Y / N	High Blood Pressure		Y / N	Anxiety
Y / N	Heart Problems	If YES, what kind? _____	Y / N	Arthritis
Y / N	Hepatitis		Y / N	Rheumatoid Arthritis
Y / N	Kidney Disease	If YES, what kind? _____	Y / N	High Cholesterol
Y / N	Circulation Problems		Y / N	Stroke
Y / N	Tuberculosis		Y / N	Diabetes
Y / N	Blood Clots or Difficulty Clotting		Y / N	Multiple Sclerosis
Y / N	Chemical Dependency (i.e. alcoholism)		Y / N	Lyme Disease
Y / N	Thyroid Problems	Hypo or Hyper?	Y / N	Depression
Y / N	Stomach Ulcers		Other: _____	

Are there any other medical issues you feel may directly impact your recovery that are not listed above?

_____

_____

335 NW Barry Road
Kansas City, MO 64155
(816) 468-5278

Medication Verification Form

Patient Name: _____ DOB: _____

Current Medications including over-the-counter medicines and supplements:

Medication	Dosage	Frequency

Patient Signature: _____ Date: _____