Patient Verification Sheet

Therapist:______________________ Account Number______________

PATIENT INFORMATION

Social Security #:______________________

Patient Name: (last)_____________ (first)________________________(MI)______

Address:______________________(city)_____________(state)______(zip)______

Phone: (home)______________________ Work:______________________________

Cell:________________________________

Date of Birth:___________________ Marital Status: (M)___ (S)___ (D)___ (W)___

Sex: (M)___ (F)___ Drivers License:____________________ State:__________

Patient Employer Name:______________________ Occupation:_________________

EMERGENCY CONTACT INFORMATION

Emergency Contact Name:_____________________ Phone:___________________

RESPONSIBLE PARTY INFORMATION (Name on Insurance Card)

Relation to Patient: (Self)___(Spouse)___(Parent)___ (always "self" for Medicare,

Always "other" for work. Comp.)

Name: (last)_________________ (first)__________________________ (MI)______

Address:______________________(City)______________(State)___ (Zip)_______

Phone: (Home)__________________ Work:_____________________ ext.______

Social Security #:____________________ Sex: (M)___(F)___ Date of Birth_________

Employer:________________________ Address:_____________________________

City:___________________ State:________________________ Zip:____________

ACCIDENT/INFORMATION

Surgery: (Y)___ (N)___ Surgery Date:________ Auto Accident State:_____________

Accident Type: (None)___ (W/C)___ (Auto)___ (Other)___

Accident/Injury/Onset Date:________ Details and Reason for Visit:____

FINANCIAL POLICY STATEMENT

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangements for payment of your estimated share be made today.

If any payment is made directly to you for services billed by us, you recognize an obligation to promptly submit same to Hunt Physical Therapy. If you do not show for a scheduled appointment or fail to contact us and cancel within five (5) hours of your scheduled appointment, you will be charged twenty-five dollars $(25.00). Insurance does not cover this charge.
Initial____________________

The above may not apply for those patients that are considered Worker's Compensation. However, be advised if you claim Workers Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

When you pay by check, you expressly authorize Hunt Physical Therapy, if your check is dishonored or returned for any reason, to electronically debit your account for the amount of the check plus a processing fee of up to the state maximum legal limit (plus any applicable sales tax) Please note: the above language authorizes an electronic debit to your account for the state-allowed recovery fee. In accordance with the rules of the National Automated Clearing House Association, you may call (888) 235-4635 to revoke the authorization for the electronic transaction. This does not, however, mean that Hunt Physical Therapy cannot collect a returned check fee by the other methods.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

Information Privacy: Hunt Physical Therapy will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operation generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policy in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities with copies for distribution. The undersigned acknowledges receipt of the information.

I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

Patient/Guardian/Responsible Party ______________________________
Date ______________________

CONSENT FOR CARE & TREATMENT

I, the undersigned, do hereby agree and give my consent for Hunt Physical Therapy to furnish medical care and treatment to ____ considered necessary and proper in diagnosing or treating his/her physical and mental condition.

Patient/Guardian/Responsible Party: X____________________________
Date:______________________

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I hereby assign all medical benefits to include major benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third party payors to Hunt Physical Therapy. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records, to secure payment.

Patient/Guardian/Responsible Party: X______________________________
Date:______________________

Hunt Physical Therapy, LLC

Zachary Hunt, DPT, CSCS

10/01/15

Re: Cancellation policy for Hunt Physical Therapy

We are blessed with a busy practice, and due to limitations on the schedule and the desire of many to get on the schedule, we have a new policy regarding cancellations. If you cancel or reschedule your appointment more than two (2) times, we may place you on a call-in only basis. What this means simply is that on the days that you ***know you have time to come to therapy***, then call us and we will work you in ***if we have space available***. You will no longer be allowed to schedule days in advance, but on a day to day basis only. We thank you for your cooperation and the opportunity to provide your physical therapy.

Professionally,

Dr. Zachary Hunt

Patient Signature and Date ______________________________

MEDICAL QUESTIONNAIRE

Pain Level- From 0-- 10 (*0 is no pain, 5 is moderate pain, and 10 is the worst pain imaginable)*

Current- ________ Best-__________ Worst-________

Surgical History (*Only those that apply to your current pain)*

____

____

____

Brief Description of Your Pain or Injury, Including Date of Onset

____

____

____

____

Pain Medicine (Dosage and Frequency)

____

____

____

Medical History- (Check All That Apply)

Heart Surgery_______

Cancer ___________

Heart Disease________

Osteoporosis_________

Dizziness____________

Stroke______________

Breathing Difficulty___

Height _____________

Osteoarthritis_______________

Headaches_______________

Hypertension_______________

Anemia_________________

Frequent Falling_____________

Fibromyalgia_______________

Rheumatoid Arthritis________

Weight _______________

Recent Imaging (MRI, CT, or X-Ray)

____

____

Work Status and Description

____

____

Your Goal for Physical Therapy

____

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