TRINITY
PHYSICAL THERAPY

Patient Information Form

Patient Information

Last Name_____First Name_____MI _____

Address_____

City _____ State _____ Zip _____

Home Phone_____ Work Phone _____ Cell Phone _____

Date of Birth_____SSN_____Gender ____ Email _____

Emergency Contact

Last Name_____ First Name_____

Relationship _____ Phone _____

Problem

Problem Description_____Onset Date_____Primary MD _____

Referred By_____Primary MD Phone _____

Motor Vehicle Accident: *Yes / No* Date_____

Primary Insurance

Insurance_____Subscriber Name_____

ID# _____Relationship to Patient _____

Group #_____Subscriber DOB _____

Secondary Insurance

Insurance_____Subscriber Name_____

ID _____Relationship to Patient _____

Group #_____Subscriber DOB _____

I authorize release of information requested by my insurance plan for payment I understand that I am financially responsible for any balance due.

I agree to comply with the terms and conditions as outlined on the Patient Registration form.

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices. (You have the right to refuse to sign this acknowledgement if you so choose.)

Signature_____Date _____

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Welcome to Trinity Physical Therapy! We understand that you have various options in selecting a healthcare provider and we are honored that you have chosen us for your new path towards healing. Our compassionate staff is committed to providing our patients with the highest quality of care possible. In doing so, we would like to provide you with some information regarding our office policies. Please feel free to speak to our Office Manager if you have any questions concerning our policies.

Uses and Disclosures of Health Information Trinity Physical Therapy may use and disclose your personal health information for treatment, obtaining payment, and healthcare operations. Please refer to Trinity Physical Therapy Notice of Privacy Practices for a complete description of uses and disclosures.

Informed Consent I have been informed that Trinity Physical Therapy is certified to provide outpatient Physical Therapy services according to the plan of care established by my referring Physician or the facility team. I understand and accept treatment accordingly.

Assignment of Benefits I hereby assign medical benefits, including major medical, private insurance, and any other health plans to Trinity Physical Therapy. This assignment will remain in effect until revoked by me. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize said assignee to release all information necessary to secure payment.

Medicare Beneficiaries I have been informed of the limits placed on Medicare Part B for outpatient Physical Therapy. I understand that if additional therapy is necessary beyond these limits, I may or may not be eligible for an exemption process.

Financial Policy Trinity Physical Therapy is dedicated to providing you with the best care possible. Understanding of our financial policy is an essential element of your care. Please ask if you have any questions about our fees, our policies, or your responsibilities.

- We will submit all billing to insurance as a courtesy for our patients.
- Payment including co-payments & co-insurances are due at the time services are rendered.
- If you have a deductible, you are responsible for all charges until the deductible is met.
- All Workers' Compensation and motor vehicle injuries must be verified for eligibility.
- Your insurance coverage is a contract between you and your insurance carrier.
- Any money paid to you by your insurance company for services billed and rendered by Trinity Physical Therapy shall be paid to Trinity Physical Therapy immediately upon receipt. Failure to do so is illegal.
- It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc.).
- I authorize payment of medical benefits from my insurance to Trinity Physical Therapy and release my medical information relating to any claims for benefits submitted on behalf of myself.
- Verification of insurance benefits does not guarantee payment. Should your insurance fail to pay, for any reason, you are responsible for the balance.

Patient Consent & Signature By signing below, I acknowledge that I have read, understood, and agreed to the provisions of Trinity Physical Therapy policies and procedures.

Print Name of Patient	Signature of Patient (Parent signature if patient is a minor)	Date

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Consent for Purposes of Treatment, Payment & Healthcare Operations

I consent to the use or disclosure of my protected health information by Trinity Physical Therapy for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Trinity Physical Therapy. I understand that analysis, diagnosis or treatment of me by Trinity Physical Therapy may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Trinity Physical Therapy is not required to agree to the restrictions that I may request. However, if Trinity Physical Therapy agrees to a restriction that I request, the restriction is binding on Trinity Physical Therapy. I have the right to revoke this consent, in writing, at any time, except to the extent that Trinity Physical Therapy has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have read and understand the Notice of Privacy Practices of Trinity Physical Therapy and understand that I have a right that Notice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Trinity Physical Therapy. The Notice of Privacy Practices is also available upon request from Trinity Physical Therapy. This Notice of Privacy Practices also describes my rights and duties of Trinity Physical Therapy with respect to my protected health information.

Trinity Physical Therapy reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling Trinity Physical Therapy and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Legal Guardian	Date
Printed Name of Patient	Printed Name of Legal Guardian

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Appointment Reminder Consent

Complete this form and sign below to give your permission for Trinity Physical Therapy to provide automatic appointment reminder service by email OR by cell phone text message.

Step one: Select ONE option below

- ☐ Trinity Physical Therapy may send email messages to confirm my upcoming appointments to email address: _____
- ☐ Trinity Physical Therapy may send cell phone text messages to confirm my upcoming appointments to phone number: _____.
  I recognize that normal text messaging rates may apply.

Step two: If you would like text messages instead of email reminders, please indicate your Cell Phone Carrier.

We cannot set your account up to send text message reminders without knowing your cell phone carrier. Please indicate your carrier below, if you would like text message reminders:

- ☐ **AT&T**
- ☐ **Boost Mobile**
- ☐ **Cingular**
- ☐ **Cricket Wireless**
- ☐ **Nextel**
- ☐ **Qwest**
- ☐ **Sprint PCS**
- ☐ **T Mobile**
- ☐ **US Cellular**
- ☐ **Verizon**
- ☐ **Virgin Mobile**
- ☐ **Other _____**

_____

Signature of Patient or Guardian

_____

Date

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Cancellation/Missed Appointment Policy

Missed appointments or appointments not cancelled in an appropriate amount of time are a lost opportunity for us to help another patient. We ask that you make every effort to keep your scheduled appointment and to arrive on time.

- A missed appointment is when you fail to show for an appointment without a phone call or cancel without prior notification.
- 24 hour notice is required to cancel an appointment. Less than 24 hour notice or missed appointments are subject to a $55 fee. This charge will not be covered by your insurance company.
- 3 or more missed appointments may result in a discharge from Trinity Physical Therapy.
- If you arrive 15 minutes late for your scheduled appointment without prior notification to our office, the appointment may have to be rescheduled and may also be considered a "missed appointment".

Please remember that communicating with our office is critical to us providing you with quality health care.

_____ _____

Patient Name Date

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Patient Intake Form

Name: _____ **Today's Date:** _____

Date of Birth: _____ **Date of Onset of Symptoms:** _____

Please answer the following:	Y	N	Date	Please answer the following:	Y	N	Date
Are you currently under a doctor's care?				Do you have arthritis?			
Have you had any recent infections?				Do you have any artificial limb or joint?			
Have you ever been diagnosed with cancer or had any tumors?				Do you have chronic neck, back, joint, or muscle pain?			
Are you pregnant?				Have you been diagnosed with a disc herniation?			

Please answer the following:	Y	N	Date	Please answer the following:	Y	N	Date
Have you ever had a heart attack?				Do you get severe headaches or migraines?			
Have you ever been diagnosed with diabetes?				Do you have epilepsy or get seizures?			
Have you ever been diagnosed with a deep vein thrombosis (DVT)?				Have you ever had vertigo or loss of balance?			
Do you have varicose veins?				Have you ever fallen?			

Please answer the following:	Y	N	Date	Please list surgical history below:	Date
Do you have high blood pressure?					
Do you get tingling or numbness into hands and feet?					
Do you experience edema or swelling in any area of your body?					
Do your hands or feet always feel cold?					

List any other diagnosed illnesses:

List Medications

Notes:

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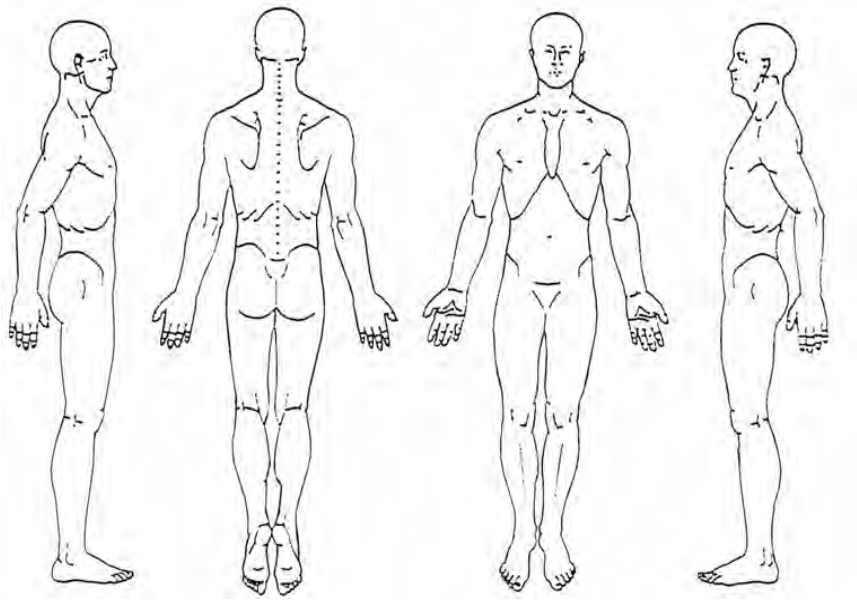
Name: _____ Date:_____

Please use scale below to mark on the diagram the <u>type</u> of pain and <u>where</u> you are experiencing it

D - Dull pain	N Numb	S Stabbing/cutting
T - Tingling	- Burnin	- Cramping



Please Mark on the line below to indicate your <u>CURRENT</u> pain level & your <u>WORST</u> pain level:

No Pain _____ **Worst Pain**

0 2 4 6 8 10

Please place a checkmark in the appropriate box regarding your health habits:

	None	Little	Moderate	A Lot
Exercise				
Sleep				
Alcohol Use				
Tobacco Use				
Drug Use				