TEAM PHYSICAL THERAPY, P.C.
PATIENT HEALTH INFORMATION

Patient Full Legal Name: _____ Goes by: _____ Date: _____

Married:____ Single:____ Divorced:____ Widowed:____ Birth Date: _____ Age Today:_____

Street Address: _____ Mailing Address: _____

City: _____ State: _____ Zip: _____ SSN: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Occupation: _____ Employer: _____ Employer City/State: _____

Referring Doctor: _____ Family Doctor: _____

I am currently receiving (circle those that apply): Home Health, Physical Therapy, Occupational Therapy, or Speech Therapy

PATIENT HEALTH HISTORY: PLEASE BE AS SPECIFIC AS POSSIBLE

	YES	NO	Date / Area			YES	NO	Date / Area
Allergies:					Osteoporosis			
Medications/Latex					Pregnancies			
Lotions/perfumes					Seizures			
Arthritis					Stroke			
Asthma					Vision Problems			
Cancer					WeightLoss/Gain			
Treatment								
COPD/Emphysema					How much/often do you exercise:			
Diabetes								
Headaches					Past Surgeries (please list):			
Heart Condition								
High Blood Pressure								
High Cholesterol								
Joint Pain					Please attach a list of all medications you are			
Muscle Pain					currently taking including dose and frequency.			
Neuralgic Issues								
Pacemaker/Defibrillator								
					Pharmacy:			

Is your visit today due to accident? Yes / No. Date of accident _____ Did you see a doctor: Yes / No
Describe your accident/injury: _____
In the past 12 months have you had 2 or more falls with no injuries? Yes / No. Falls with injury? Yes / No
How long have you been hurting? _____ Date of onset of pain: _____
Were the injuries repaired with any surgical procedures? Yes / No. Date of Surgery: _____
Area to be treated: _____
Reason for Treatment (what caused the pain/problem? Be specific):

TEAM PHYSICAL THERAPY, P.C.
AUTHORIZATION AND CONSENT FOR TREATMENT

PATIENT'S NAME: _____ TODAY'S DATE: _____
Date of Accident/Injury _____ Work related injury Yes / No
Motor vehicle accident: Yes / No Liability Claim Yes / No
If you answered Yes to any of the above please complete Work Comp/Liability Authorization.

Please read, complete and initial each of the following:

_____/ I hereby authorize TEAM Physical Therapy, P.C. staff to administer all outpatient physical therapy treatments and procedures as deemed medically necessary.

_____/ I hereby authorize TEAM Physical Therapy, P.C. to provide copies of my physical therapy notes as requested by my insurance/assurance company, attorney or any other outside source representing me. I authorize the release of any information including the diagnosis and the records of any treatment/examination rendered to me (or my dependent) during the period of such care to third party payers and/or other health care practitioners. I understand that I am responsible for the cost of postage/copying fees for these documents. I agree to payment of these fees in the event that the representing party's policy prevents them from paying for this service. I understand that a separate HIPPA authorization release may be needed from me for each party requesting documentation.

_____/ Including myself, the following person(s) or organization(s) are authorized to receive my health information
Name:_____ Relationship:_____
Name:_____ Relationship:_____
Name:_____ Relationship:_____
I understand I may revoke this at any time by written notification.

_____/ In the event of an emergency I request TEAM Physical Therapy contact the following:
Name: _____ Phone: _____ Relationship: _____
Name: _____ Phone: _____ Relationship: _____

_____/ I have been offered a copy of TEAM Physical Therapy, P.C. Notice of Privacy Practices containing a complete description of the use and disclosure of my health information. I understand that this business has the right to change the Notice of Privacy Practice and I may contact TEAM Physical Therapy, P.C. at any time to request a current updated copy of the Notice of Privacy Practices

_____/ I have a Supplemental Assurance Plan (AFLAC, Colonial Life, Broker's National, Student Assurance Etc.) and upon discharge from care would like a full statement of my case sent to the following agent. I consent to allow TEAM Physical Therapy PC staff to discuss my treatment and billing statement with my agent to answer any questions or release copies of my notes as they pertain to this case only.

Assurance Company: _____ Agent's Name: _____

Agent's City/State: _____ Agent's Phone Number: _____

The undersigned has read and completed all the above information accurately.

Signed: _____ OR_____
Patient (must be 19) Authorized person / relationship to patient

Date _____ Time: _____A.M. / P.M. Witness: _____

TEAM PHYSICAL THERAPY, P.C.
INSURANCE AUTHORIZATION, RELEASE and FINANCIAL EXPECTATIONS

Patient Name:_____ Today's Date: _____

TEAM Physical Therapy, P.C. will file your claims to the insurance carrier that you provide. With your signature below you are authorizing your insurance company to pay directly to TEAM Physical Therapy, P.C. benefits otherwise payable to you, but not to exceed the clinic's regular charges for services provided. A current listing of all insurance carriers we are participating providers with will be posted or made available upon request for your review.

As a patient you are responsible to know what your physical therapy benefits include (deductible, coinsurance, visit limit, prior authorization, physician referral, etc.) Our Billing Team calls your insurance company the day after your first visit to review your physical therapy benefits. If you would like to visit with our Billing Team to learn more about your insurance benefits or get an estimated cost of your care please contact them at (308)872-5111 between 8 and 5 Monday – Friday. TEAM Physical Therapy, P.C. can NOT give you an exact cost of your care until your insurance has finished processing your claims. If a settlement or lawsuit is pending regarding your injury you will be responsible to make monthly payments on your account until the balance is paid in full.

Please read and answer each item below:

YES / NO I authorize TEAM Physical Therapy, P.C. to have Navicure Payment Services send electronic account billing statements/invoices to my provided email address on file. I understand that I will not receive a copy of any such invoice via US Mail. I understand that it is my responsibility to maintain a current email addresses on file and that this authorization will remain in effect until I provide written notice of cancellation. I understand that I can cancel the authorization only for future services. Authorization for services already rendered cannot be cancelled. I understand that my email will be kept private and not shared with any other person or business and will only be used for billing account and not advertising or other communications. _____email (person responsible for account).

YES / NO I authorize TEAM Physical Therapy, P.C. to apply charges to my payment card, debit/credit card or bank account for all amounts owed during the course of this current course of treatment including; agreed upon monthly payment plan amounts, co-payments, coinsurances, amounts not covered by insurance, late fees, and appointment cancellation fees. I agree to notify TEAM Physical Therapy, P.C. in writing of any changes in my payment or address information. If yes: *Please complete Automatic Payment Authorization form if enrolling in our auto pay program.*

I understand I am responsible for payment of all services rendered on my (or my dependent's) behalf. I will keep my account current and settle any discrepancies with my insurance company personally. I understand any unpaid balance on my account (after the due date) will incur a 1.33% monthly late fee charge (16% annual) that will be added to my outstanding balance that I am also responsible for.

The undersigned has read and completed all the above information accurately.

Signed: _____ OR _____
Patient (must be 19) Authorized Person / Relationship
Date _____ Time: _____A.M. / P.M. Witness: _____

TEAM Physical Therapy P.C.
Worker's Compensation / Liability Pre-Authorization & Approval Form

Patient Name: _____ Date of Injury: _____

Name of Employer/Company: _____ Phone # of Employer: _____

Place of Accident _____ Town _____ State _____

Name of Case Adjustor / Case Manager:_____

Phone # of Case Adjustor/ Case Manager:_____

Case/Claim Number: _____

Was Employer/Company Notified of Injury: Yes ___ No ___
Have you seen a doctor: Yes ___ No ___
Has a report been filed with your employer/company: Yes ___ No ___

Specific details of injury (body part injured): _____
_____
_____
_____

To my knowledge, my employer/company and I are in agreement that my injury is being covered by Worker's Compensation/Liability. The above statements are complete to the best of my knowledge. I understand that although the insurance claims for this injury will be submitted, TEAM Physical Therapy, P.C. cannot guarantee payment, and if Workers' Compensation/Liability Insurance denies this claim, I agree to pay for all charges. My signature also gives permission for claims to be sent to the Employer/Company listed above.

The undersigned has read and completed all the above information accurately.

Signature _____ Date _____

Office Use Only

Referring Doctor: _____

Referral Frequency and Duration: _____

ICD10 Code(s): _____

Treating Physical Therapist: _____

TEAM PHYSICAL THERAPY, P.C.
AUTOMATIC PAYMENT AUTHORIZATION

Patient Name: _____ Today's Date:_____

I have elected to sign up for automatic payment of my account balance using either a credit card or bank account. I authorize TEAM Physical Therapy, P.C to debit the account I have provided below for the listed amount on the listed date of each month until my account has been paid in full. I understand that this authorization only applies to this current case and that I must sign up for this service for each future course of treatment I may need. I understand that TEAM Physical Therapy, P.C. will maintain strict security of my financial information and not share this information with any individual, company or business.

Credit Card Type: _____ (Visa, Master Card, Discover, Care Credit)
Name on Front of Card: _____
Billing Address for Card: _____
Expiration Date on Card: _____
Card Number: _____Security Number on Back of Card:_____

Or

Name of Bank:_____
Name on Account: _____
Address of Account Holder: _____
Bank Routing Number:_____
Bank Account Number: _____

Amount to be Processed Each Month: _____

Date each month I want my account debited: _____

___ I would like a receipt of this transaction: emailed to _____

___ I would like a receipt of this transaction mailed to the following address:
_____

___ I do NOT want a receipt.

Payer Signature: _____ Date: _____

Payer Printed Name: _____