BLACK HILLS PHYSICAL THERAPY, INC.

PATIENT INFORMATION FORM

Patient Information

Last Name _____ First Name _____ SSN _____

Date of Birth _____ Gender _____ Marital Status _____

Address _____

City _____ State _____ Zip _____

Home Phone # _____ Work Phone # _____ Cell Phone # _____

Email _____

REMINDER (circle one): Text Email Call Paperless Statement: Y N Text Email

Emergency Contact

Last Name _____ First Name _____

Relationship _____ Phone # _____

Employer Information (Or parent/guardian employer information)

Name _____ Phone # _____

Address _____

City _____ State _____ Zip _____

Problem

Problem Description _____ Date of Injury _____ Last Physician Visit _____

Referred by _____ Previous PT for this issue: Y N

Goals for Therapy: _____

HIPAA Consent

I have been given the right to review such Notice of Privacy practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the notice.

I understand that I may revoke this consent in writing at any time except to the extent that Black Hills PT has taken action relying on this consent. **Please initial:** _____

I do hereby agree and give my consent for Black Hills PT furnish medical care, testing and treatment considered necessary and proper in diagnosing or treating my/his/her physical condition. Please initial: _____

How did you hear about us? Please circle any that apply.

Doctor **Newsletter** **Friend** **Website** **Social Media** **Event**

Other_____

Patient's Signature: _____ Date: _____

MEDICAL HISTORY

Patient Name _____ Patient Case/Condition _____
Referring Physician _____ Primary Physician _____

Date of injury /Onset Date _____

Have you had surgery? Yes No Type of Surgery _____
Surgeries (Cont): _____

Are you currently taking any prescription or non-prescription medications: Yes No If yes please list:

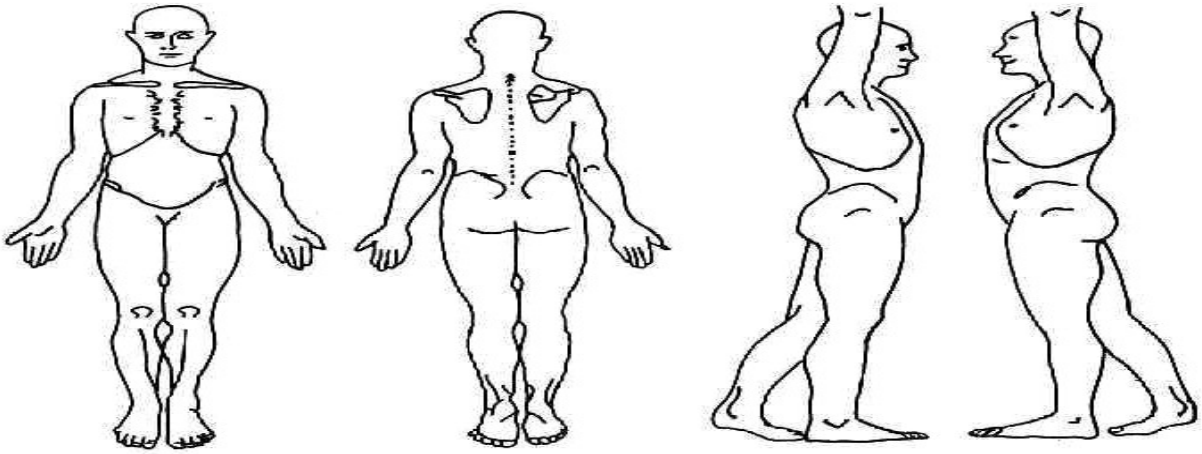
_____

_____

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

Asthma	Y N	Severe or Frequent Headaches	Y N
Shortness of Breath/Chest Pain	Y N	Numbness/Tingling	Y N
High Blood Pressure	Y N	Dizziness/Fainting/Vertigo	Y N
Coronary/Congestive Heart Disease	Y N	Bowel/Bladder problems	Y N
Pacemaker/Defibrillator	Y N	Kidney Disease	Y N
Heart Attack	Y N	Hepatitis/Jaundice	Y N
Stroke/TIA	Y N	Cirrhosis/Liver Disease	Y N
Blood Clot	Y N	Polio	Y N
Cancer/Chemotherapy/Radiation	Y N	Allergies	Y N
Epilepsy/Seizures	Y N	Latex Allergy	Y N
Thyroid Disease	Y N	Any pins or metal implants	Y N
Anemia	Y N	Chronic Bronchitis/Pneumonia	Y N
Infectious Disease	Y N	Emphysema	Y N
Diabetes	Y N	Ulcers	Y N
Hypoglycemia	Y N	Alcohol/Drug Abuse	Y N
Arthritis	Y N	HIV/AIDS	Y N
Osteoporosis	Y N	Do you Smoke?	Y N
Depression	Y N	Have you ever Smoked	Y N
Emotional/Psychological problems	Y N	Do you regularly exercise?	Y N

Mark on the picture where you are having your symptoms, please be specific: X for pain, O for numbness, B for burning



Therapist's Signature: _____ Date:_____

Patient's Signature: _____ Date_____

FINANCIAL POLICY/ASSIGNMENT OF INSURANCE BENEFITS

Our office staff will call and verify all insurance coverage that you may have, and contact you to provide an estimate of what each visit will cost. This amount is an estimate and the actual amount due may differ. You are responsible for any difference in what was quoted by your insurance company and what was actually paid. We recommend that you call your insurance carrier to gain understanding of your benefits. We will do everything in our power to ensure that we have the necessary referrals or authorizations, however it is ultimately your responsibility to verify that all visits are covered by a referral or authorization. Any charges incurred that are not covered by your insurance become your responsibility.

I do hereby authorize my insurance carriers to pay directly to Black Hills PT the insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for any charges transferred to by my insurance carrier(s), including: co-pay, deductible and co-insurance amounts as well as those not covered by my insurance. I agree to pay all attorney fees, court costs, filing fees including commissions that may be assessed to me by any collection agency retained to pursue such matters. Payment of estimated charges are due at the time of service unless other arrangements are made.

Responsible Party

Name _____ SSN _____ DOB _____

Phone Number if Different _____ Address if Different _____

Primary Insurance

Company _____ ID# _____ Group # _____

Subscriber Name _____ Subscriber DOB _____ Relationship _____

If Medicare: Have you been on Home Health Services Yes No Discharge Date _____

Have you had PT/OT this year? Yes No

Secondary Insurance

Company _____ ID# _____ Group # _____

Subscriber Name _____ Subscriber DOB _____ Relationship _____

****Must Provide Card for a Copy****

**If Workers Compensation or Auto Insurance, patients still need to provide us with their Private Insurance Information

Workers Compensation

Paying Agency/State _____ Case # _____

Case Manager _____ Phone# _____

Date of Accident _____ Employer at the Time of Injury _____

Supervisor _____ Employer Phone # _____

Employer Address _____ Employer City, State, Zip _____

Auto Insurance

Insurance Company _____ Address _____

Claim # _____ Date of Accident _____

Adjuster _____ Phone # _____

Patient's Signature: _____ Date_____

MISSED VISIT POLICY

Thank you for choosing Black Hills Physical Therapy as your physical therapy provider.

At Black Hills Physical Therapy, we are committed to providing you with quality care and a positive experience. It is our goal to help all patients reach a fully recovered state. Your physical therapist will provide you with your plan of care during the evaluation appointment and will inform you of the required number of visits to help you achieve your goals.

Please read and sign indicating you understand our expectations and our policy.

1. To help ensure you have the best chance at recovery, we will work with you to schedule all of your appointments after your evaluation today. In order to have the best chance for recovery, you will need to attend each visit.

2. If you are running late for your appointment, we need you to **call us immediately, if able,** so we can prepare for your late arrival and consult with your clinician. If you are more than 15 minutes late, your session may need to be rescheduled at the next most convenient time

3. I**f more than one session is missed without us being notified, a fee will be charged for each missed visit.**

   There is a $60 missed visit charge if you do not provide at least 24 hours advanced notice during business hours of your appointment change or cancellation.

   This is a non-negotiable fee. It is your responsibility as insurance will not cover this fee.

4. To avoid our missed visit fee, **call our office during business hours-**at least ONE DAY in advance for any appointment changes or cancellations. If you feel you might need to reschedule or cancel a Monday appointment, please call by 3PM on Friday afternoon, if able.

5. Patients who have multiple same-day cancellations or no-shows will be removed from the schedule and notified of this.

6. If you have worker's compensation, we are required to notify your case manager if you cancel or no show for an appointment.

We look forward to working with you to meet your physical therapy goals.

I have read and acknowledge that I understand this policy.

Signature_____Date:_____