

Patient Data Sheet

Name \_\_\_\_\_  
 Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Work# ( ) \_\_\_\_\_ - \_\_\_\_\_ ext. \_\_\_\_\_ Home# ( ) \_\_\_\_\_ - \_\_\_\_\_  
 SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Sex  Male  Female Marital Status:  M  S  D  W  
 DOB \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Email \_\_\_\_\_ Cell Phone# \_\_\_\_\_  
 Notify in case of Emergency \_\_\_\_\_ Phone# \_\_\_\_\_

Employer _____ Street _____ City _____ State _____ Zip _____ Occupation _____	<u>Employee Type</u> <input type="checkbox"/> Retired <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Not Employed	<u>Student Type</u> <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Non Student
---	---	---

Name of Insurance Carrier (Primary)  
 Medicare  Medicaid  Major Medical  Self Pay  
 Other \_\_\_\_\_  
 Name \_\_\_\_\_  
 Street \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Policy # \_\_\_\_\_  
 Group # \_\_\_\_\_  
 Policy Effective Date \_\_\_\_\_  
 Phone # ( ) \_\_\_\_\_

Name of Insurance Carrier (Secondary)  
 Medicare  Medicaid  Major Medical  Self Pay  
 Other \_\_\_\_\_  
 Name \_\_\_\_\_  
 Street \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Policy # \_\_\_\_\_  
 Group # \_\_\_\_\_  
 Policy Effective Date \_\_\_\_\_  
 Phone # ( ) \_\_\_\_\_

Insured Information  
 Name \_\_\_\_\_  
 Relationship to patient \_\_\_\_\_  
 Employer \_\_\_\_\_  
 Street \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Male  Female Marital Status \_\_\_\_\_

Insured Information  
 Name \_\_\_\_\_  
 Relationship to patient \_\_\_\_\_  
 Employer \_\_\_\_\_  
 Street \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Male  Female Marital Status \_\_\_\_\_

Date of Accident \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  Work Related  Auto  Other \_\_\_\_\_  
 Onset of Symptoms \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Hospitalization Dates \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ to \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Referring Physician \_\_\_\_\_ NPI# \_\_\_\_\_  
 Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone ( ) \_\_\_\_\_ - \_\_\_\_\_ Fax ( ) \_\_\_\_\_ - \_\_\_\_\_  
 Diagnosis/Reason for Visit: \_\_\_\_\_

This information will be used for billing purposes.  
 Please present your insurance card and a photo id to the front desk receptionist.  
 I have reviewed the above information and verify that is correct.  
 Patient's/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Patient Medical Intake Form

Name: \_\_\_\_\_ Referring Physician \_\_\_\_\_

Family Physician: \_\_\_\_\_ Date of first doctor visit for this injury: \_\_\_\_\_

Last date worked due to this injury: \_\_\_\_\_ Date returned to work after this injury: \_\_\_\_\_

Is an attorney involved in this case?  Yes  No

Have you had a surgery for this injury?  Yes  No      Number of Surgeries: 1 2 3 4 other \_\_\_\_\_

Type of Surgery: \_\_\_\_\_

Where did the surgery take place: \_\_\_\_\_

Are you currently taking any prescription or non-prescription medications?  Yes  No

Anti-inflammatories \_\_\_\_\_ List of Medications \_\_\_\_\_

Muscle Relaxers \_\_\_\_\_

Pain Medication(s) \_\_\_\_\_

Have you had any of the following Medical or Rehabilitative services for this episode/injury?

	YES	NO		YES	NO
Chiropractor	<input type="checkbox"/>	<input type="checkbox"/>	CT Scan	<input type="checkbox"/>	<input type="checkbox"/>
EMG/NCV	<input type="checkbox"/>	<input type="checkbox"/>	General Practitioner	<input type="checkbox"/>	<input type="checkbox"/>
Massage Therapy	<input type="checkbox"/>	<input type="checkbox"/>	MRI	<input type="checkbox"/>	<input type="checkbox"/>
Myelogram	<input type="checkbox"/>	<input type="checkbox"/>	Neurologist	<input type="checkbox"/>	<input type="checkbox"/>
Occupational Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Orthopedist	<input type="checkbox"/>	<input type="checkbox"/>
Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Podiatrist	<input type="checkbox"/>	<input type="checkbox"/>
Emergency Room Care	<input type="checkbox"/>	<input type="checkbox"/>	X-Rays	<input type="checkbox"/>	<input type="checkbox"/>
Other _____					

To the best of your knowledge, do you now have or have you had ever ANY of the following?

	YES	NO		YES	NO
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Blood in Stool/Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack or surgery	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pains/Angina	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Polio/Muscle Disease	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Severe or Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	TMJ Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Infectious Disease	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Fatigue Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	Lyme's Disease	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Pain	<input type="checkbox"/>	<input type="checkbox"/>
Concussion	<input type="checkbox"/>	<input type="checkbox"/>	Night Pain	<input type="checkbox"/>	<input type="checkbox"/>
Fainting Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Unexplained Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety/Panic Attacks	<input type="checkbox"/>	<input type="checkbox"/>	Cancer/Tumors/Growths	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis Swollen Joints	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Stroke/TIA	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Do You Smoke?	<input type="checkbox"/>	<input type="checkbox"/>	Fractures	<input type="checkbox"/>	<input type="checkbox"/>
			Date: _____ Area: _____		

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Consent for Care and Treatment**

I, the undersigned, do hereby agree and give my consent to **Colonial Physical Therapy** and all its health care professionals using its facility to furnish medical care and treatment to (please print) \_\_\_\_\_ considered necessary and proper in diagnosing or treating his/her physical and mental condition. These interventions are in accordance with the State Practice Act for their respective professions.

**Patient/Guardian/Responsible party** \_\_\_\_\_ **Date** \_\_\_\_\_

**Assignment of Insurance Benefits/Release of Information**

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third party payors to **Colonial Physical Therapy**. I also request payment of government benefits either to myself or to the party who accepts assignment. 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** \_\_\_\_\_ **Date** \_\_\_\_\_

**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 your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your company establishes an internal usual and customary fee schedule, you will be responsible for the difference remaining.

If any payment is made directly to you for services billed by us, you recognize an obligation to promptly submit same to Colonial Physical Therapy.

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

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.

**I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.**

\_\_\_\_\_

**Patient/Guardian/ Responsible Party**

\_\_\_\_/\_\_\_\_/\_\_\_\_

**Date**

\_\_\_\_\_

**Patient/Guardian/ Responsible Party**

\_\_\_\_/\_\_\_\_/\_\_\_\_

**Date**

## Physical Therapy Attendance Policy

**Colonial Physical Therapy** is dedicated to patient satisfaction and the highest quality care while attempting to accommodate your treatment schedule. Therefore, we provide reserved appointments for each patient in order to minimize waiting and assure the continuity of treatment. Only two visits are scheduled each hour. Your consistent attendance is vital to your recovery. Please adhere to the duration and frequency of your physical therapy treatment per your physician’s prescription.

Cancellations, along with no-shows, decrease our ability to accommodate the scheduling needs of other patients. Your full cooperation is required with the following policy:

- If you are unable to keep a scheduled appointment, please notify our office 24 hours in advance via our toll free telephone number or email us at our website [www.colonialpt.com](http://www.colonialpt.com);
- All Cancellations and no –shows will be documented in your medical record and appropriately reported to your physician, insurance company, case manager and/or employer;
- If you acquire 3 or more cancellations or no –shows, your therapist may refer you back to your physician before scheduling another appointment or may choose to discharge you from therapy and report this to your physician.
- A charge of \$15.00 may be assessed for all missed appointments (except if our office is notified 24 hours in advance).

## Referral and Prescription Policy

Insurance regulations require that referrals and prescriptions be presented to your physical therapist at the time of your visit.

***It is your responsibility to keep track of the number of visits allowed and the valid period of referral and prescription. Failure to do so may result in treatment that was not authorized by your insurance carrier, and any charges incurred for these unauthorized visits would be your full responsibility.***

## Payment Policy

Copays or fees for service are due and payable at the time of service. Noncompliance may cause an interruption in your treatment schedule.

I acknowledge and understand the above:

\_\_\_\_\_

\_\_\_\_/\_\_\_\_/\_\_\_\_

**Patient/Guardian/ Responsible Party**

**Date**