Welcome to Angeline Physical Therapy, LLC (dba, Angeline Physical & Aquatic Therapy)

PATIENT'S INFORMATION SECTION

Patient's Last Name _____ Patient's First Name _____

Patient's Address _____ City _____ St_____ Zip _____

Patient's HOME PHONE # _____ Patient's CELL PHONE # _____

Patient's Date of Birth: ____/____/____ Patient's Sex: M F

Patient's Marital Status (Please Circle one): *Married* *Single* *Divorced* *Widowed*

Domestic Partner *Legally Separated*

Patient's SS#: _____-_____-_____ Email Address: _____

Patient's Employment Status (Please Circle one): *Full Time* *Part Time* *Retired* *NA*

Employer's Name _____ Employer's Phone # _____

Student Status (Please Circle one): *Full Time* *Part Time* *School Name*_____ ***NA***

What is the name of the physician who prescribed your Physical Therapy? _____

Physician's Address (if known): _____ City _____ St_____ Zip _____

Are you currently receiving Home Health Care? (Please Circle one): Yes No

INSURANCE SUBSCRIBER & INSURANCE INFORMATION

PRIMARY INSURANCE

Name of Subscriber: _____ Birthdate: ____/____/____

Relationship to Patient: _____ Phone: (____) _____-_____

SS#_____-_____-_____ Insurance Co: _____

Subscriber #:_____ Group #/Name: _____

SECONDARY INSURANCE ***If you have NO Secondary Coverage Initial Here (_____)

Name of Subscriber: _____ Birthdate: ____/____/____

Relationship to Patient: _____ Phone: (____) _____-_____

SS#_____-_____-_____ Insurance Co: _____

Subscriber #:_____ Group #/Name: _____

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PATIENT CONSENT

CONSENT TO PHYSICAL THERAPY TREATMENT: I am being treated at Angeline Physical Therapy, LLC (dba Angeline Physical & Aquatic Therapy) physical and aquatic therapy office ("Physical Therapy Office"), and I consent to all physical & aquatic therapy care, evaluations and tests determined by the Physical Therapy Office to be necessary for me. Though I expect the care given will meet customary standards, I understand there are no guarantees concerning the results of my care. I assume full risk and responsibility and release the Physical Therapy Office and any individual provider from responsibility for things that might go wrong if I do not receive the medical care and treatment recommended to me.

CONSENT TO USE OF INFORMATION: Electronic Health Records: I understand that the Physical Therapy Office may collaborate with other health care providers to coordinate, manage, and provide health care to me and I consent to the Physician Office's sharing my health information and records electronically for the purposes of treatment, payment or operations, including improving the overall quality of health care services provided to me. I consent to the inclusion in the electronic health records of sensitive diagnoses and related information such as HIV/AIDS status, sexually transmitted diseases, genetic information, and mental health and substance abuse, etc. The electronic health records (EHR) will be accessible by Angeline Physical Therapy, LLC employees, credentialed practitioners as well as other individuals approved to access the EHR for purposes related to treatment, billing, payment, treatment documentation, health care operations, and/or other purposes permitted by federal and state laws, including the Health Insurance Portability and Accountability Act ("HIPAA"). The Physical Therapy Office has implemented administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality and integrity of my medical information as required by HIPAA.

USE AND DISCLOSURE OF INFORMATION: In addition to the above consent to use and share my health information with Angeline Physical Therapy, LLC, I agree that the Physical Therapy Office may use and disclose my health information for a range of purposes including: treatment, eligibility verification, and/or payment to private and public payers or their agents including insurance companies, managed care organizations, my employer (if I am injured at work), state and federal government programs, Workers' Compensation programs, obtaining treatment pre-authorization, quality of care assessment and improvement activities, evaluating the performance and qualifications of physical therapy licensed personnel, students, and support staff, conducting physical therapy, physical therapist assistant, and athletic training education and clinical programs, conducting or arranging for medical review, audit services, ensuring compliance with legal, regulatory and accreditation requirements and public health and health oversight services.

Request for Information from Others: I consent to the Physical Therapy Office's request of my health information from other providers of care to me, receipt of and release of my health information, whether written, verbal, or electronic, for the uses described above.

ASSIGNMENT OF BENEFITS: I hereby assign to and authorize payment of all insurance and health care benefits available to me directly to the Physical Therapy Office for services provided to me. I understand that benefits may be payable to me directly if I do not provide this authorization.

FINANCIAL RESPONSIBILITY: I understand and agree that I am financially responsible for payment of all charges incurred which are not paid by insurance or health care benefits, including any and all products provided or services rendered to me which are not eligible for payment (non-covered) under health care plans, Medicare,

Medicaid or other insurance or payers. Non-covered services also may include those services my physical therapist determines to be medically necessary, but are later determined unnecessary by the payer.

PERSONAL VALUABLES: I understand that the Physical Therapy Office does not accept responsibility for any lost, stolen or damaged personal items while I am at the Physical Therapy Office.

WE REQUIRE A COPY OF ALL LEGAL DOCUMENTS REGARDING GUARDIANSHIP AND CUSTODY.

CHAPERONE: I understand that the Physician Office allows for a chaperone during my visit and I will let my provider or the staff know if I would like a chaperone present.

PLEASE NOTE ONLY THE PATIENT AND/OR THEIR LEGAL REPRESENTATIVE SHOULD SIGN THIS FORM.

I agree to all of the above uses and disclosure and understand this will remain in effect until I notify Angeline Physical Therapy, LLC of any changes.

Patient Name (Print Legal Name)_____

Patient Date of Birth_____

Signature of Patient/Patient's Legal Representative_____

Date & Time_____

Print Name of Patient's Legal Representative_____

Relationship to Patient_____

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FINANCIAL POLICY AND INSURANCE INFORMATION

I understand and agree that insurance claim forms will be submitted to my insurance company as a matter of convenience only, and that **I am responsible for all the charges regardless of my existing medical coverage.** I hereby give authorization for payment of insurance benefits to be made directly to APT for services rendered. In the event that my insurance company forwards payment directly to me, instead of APT, I will immediately deliver said payment to APT.

I understand and agree that I am wholly responsible and liable for payment of all charges assessed for professional services rendered and will pay any sum due, upon demand. Failure to pay the entire balance due on a statement within a month will result in a $10.00 service fee being added to my next statement balance. I understand and agree after 90 days of a balance being unpaid that if APT deems it necessary to utilize an outside collection agency or to commence court action for the collection of any outstanding charges, I will be responsible for the outstanding balance (plus a $50 processing fee), and any additional attorney fees, court costs and other expenses of litigation. I also understand that failure to show for or cancel my scheduled appointment within 24 business hours of its scheduled time will result in a $25.00 fee applied to my bill.

_____Date:_____ Relationship to Patient: _____

Signature of Person Responsible for Charges

(Parent or legal guardian must sign if patient is under 18 years of age)

ACKOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I understand APT reserves the right to modify the privacy practices outlined in the notice and I have received or been offered a copy of the Notice of Privacy Practices for APT.

(Please Circle One) **Received** **Offered**

Signature: _____Date:_____

(Parent or legal guardian must sign if patient is under 18 years of age)

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Authorization To Release Information

Besides the physician(s), healthcare providers, and staff outlined in the "Patient Consent" section, please indicate anyone with whom Angeline Physical Therapy, LLC and/or Angeline Physical & Aquatic Therapy (APT) may discuss aspects of your treatment. These aspects primarily would include your health, medical and/or billing information and/or your scheduled appointments.

1) _____ _____ _____
Name Relationship Phone #

2) _____ _____ _____
Name Relationship Phone #

3) _____ _____ _____
Name Relationship Phone #

I, _____ **DO** Authorize APT to release/discuss, my health, medical, billing, and appointment information to the above named individuals.

_____ _____
Patient's Signature (Guardian's if under 18 years of age) Date

****

I, _____ **DO NOT** Authorize APT to release/discuss, my health, medical, billing, and appointment information to anyone other than outlined in the "Patient Consent" section.

_____ _____
Patient's Signature (Guardian's if under 18 years of age) Date

****

I furthermore authorize information regarding my health, medical, billing, and appointment times to be (please initial all that you approve):

Left on my voicemail (please initial) _____

Left on all other contact voicemails listed above (please initial) _____

Emailed to the email I provided in the "Patient's Information Section" (please initial) _____

I would like to receive Appointment Reminders By Email? (please initial) _____

I would like to receive Appointment Reminders By Text? (please initial) _____

Patient Instructions

(Please **Initial the line** next to each number)

_____1) Our physical therapists are **Jeff Angeline MEd, PT, AT and Dr. Kara Campbell, DPT, PT.** Our Physical Therapy Assistant is **James Strausbaugh, PTA**. If you have any questions regarding your physical therapy plan, please feel free to ask one of them at any time.

_____2) Please be aware that there will be students/aides that will assist you in your program as well. This is a great environment for a "hands on" learning experience that we can provide them.

_____3) Please be on time for your scheduled appointments. Please call in advance if you are running late for your scheduled appointment. If you arrive late without calling, your treatment time may be lessened and in some cases, we may not be able to work with you on that day.

_____4) Failure to cancel within 24 business day hours or failure to show for your scheduled appointment will result in a $25.00 fee applied to your bill. In the event a third party such as worker's compensation is paying for your treatments, this fee will be your (not their) responsibility.

_____5) **VERY IMPORTANT !!!** We like to stay in contact with your referring doctor. When you are scheduling your PT appointments, please alert the scheduler one week in advance of any upcoming follow-up appointments with your physician. That way we can properly schedule time to reevaluate you and provide him/her a PT progress report.

_____6) When you see your doctor, please get a new, updated prescription to continue physical therapy. The doctor can either sign the progress note we send or write up a new prescription.

_____7) If you are scheduling two times per week, we ask you not to schedule 2 days in a row if possible. If you are scheduling 3 times a week, you are allowed to schedule 2 of the days in a row but not 3 days in a row.

_____8) **Insurance**: Your insurance benefits are a **contract between you and your insurance company**. It is **your** responsibility to be aware of your benefits, so we encourage you to call them and verify your coverage. As a courtesy, we will also try to call them after your initial evaluation and review them with you. However, we CANNOT be responsible for any information misquoted to us by your insurance company's representatives, or if we cannot get in touch with them in a timely manner.

HOURS OF OPERATION

Monday	Tuesday	Wednesday	Thursday	Friday
7:00-1:00	**8:00-12:00**	**8:00- 12:00**	**9:00-1:00**	**7:00-12:00**
2:00-7:00	**1:00-5:00**	**Closed at**	**2:00-7:00**	**1:00-5:00**
Lunch 1-2:00	***Lunch 12-1:00***	**12 Noon**	***Lunch 1-2:00***	***Lunch 12-1:00***

****Please like us on Facebook under Angeline Physical & Aquatic Therapy. Stories about your experiences at our facility are always welcome.**

Medical History

Name: D.O.B.

Existing or Relevant Previous Conditions

Allergies	◯Yes◯No	Dizzy Spells	◯Yes◯No	MRSA	◯Yes◯No
Anemia	◯Yes◯No	Emphysema/Bronchitis	◯Yes◯No	Multiple Sclerosis	◯Yes◯No
Anxiety	◯Yes◯No	Fibromyalgia	◯Yes◯No	Muscular Disease	◯Yes◯No
Arthritis	◯Yes◯No	Fractures	◯Yes◯No	Osteoporosis	◯Yes◯No
Asthma	◯Yes◯No	Gallbladder Problems	◯Yes◯No	Parkinsons	◯Yes◯No
Autoimmune Disorder	◯Yes◯No	Headaches	◯Yes◯No	Rheumatoid Arthritis	◯Yes◯No
Cancer	◯Yes◯No	Hearing Impairment	◯Yes◯No	Seizures	◯Yes◯No
Cardiac Conditions	◯Yes◯No	Hepatitis	◯Yes◯No	Smoking	◯Yes◯No
Cardiac Pacemaker	◯Yes◯No	High Cholesterol	◯Yes◯No	Speech Problems	◯Yes◯No
Chemical Dependency	◯Yes◯No	High/Low blood pressure	◯Yes◯No	Strokes	◯Yes◯No
Circulation Problems	◯Yes◯No	HIV/AIDS	◯Yes◯No	Thyroid Disease	◯Yes◯No
Currently Pregnant	◯Yes◯No	Incontinence	◯Yes◯No	Tuberculosis	◯Yes◯No
Depression	◯Yes◯No	Kidney Problems	◯Yes◯No	Vision Problems	◯Yes◯No
Diabetes	◯Yes◯No	Metal Implants	◯Yes◯No		

Describe any other conditions

If "Yes" to Any of the above, please explain and give approximate dates/Describe any other Conditions.

Fall History

Injury as a result of a fall in the past year? ◯Yes◯No

Two or more falls in the last year? ◯Yes◯No

Patient at risk for falls? ◯Yes◯No

Hand Dominance ◯Right◯Left

Surgical History

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

Current Medications

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

- **Currently not taking any medications**