BLACK HILLS PHYSICAL THERAPY PATIENT INFORMATION

Date_____

Patient Name:_____ Social Security #:_____

Address:_____City_____State_____Zip_____

Home Phone_____Cell _____Work_____

Birth Date_____Age_____Email_____

Gender: Male Female Marital Status: S M W D

Employer_____ Occupation_____

Address_____City_____State____ Zip_____

Spouse Name:_____Birth Date _____ Phone number_____

Referring MD_____Primary Care MD_____

EMERGENCY CONTACT_____Phone_____

FINANCIALLY RESPONSIBLE PERSON (if other than yourself)

Name_____Relationship_____

Address_____City_____State____Zip_____

Home Phone_____Cell_____

Employer_____City_____State_____Zip_____

MEDICAL INSURANCE

Name (Primary)_____ID#_____

Address:_____City_____State____Zip_____

Policy Holder Name_____Date of Birth_____

Name (Secondary)_____ID#_____

Address:_____City_____State____Zip_____

WORKERS' COMPENSATION

WC Insurance Name_____Claim #_____

Address:_____City_____State____Zip_____

Case Manager/Claims Adjustor Phone_____Date of Injury_____

Employer Name_____

HEALTH HISTORY

Height_____ Weight_____Bp_____

Chief Complaint_____

Medications (prescription and non-prescription, include doses)_____
_____

Surgeries (include dates)_____
_____

Imaging/X-rays/MRI/CT: Yes/ No If yes, Where_____

PAST OR PRESENT MEDICAL HISTORY (please circle)

Diabetes	Yes	No	Cirrhosis/Liver Disease	Yes	No
Hypoglycemia	Yes	No	Polio	Yes	No
High Blood Pressure	Yes	No	Chronic Bronchitis	Yes	No
Heart Disease	Yes	No	Pneumonia	Yes	No
Chest Pain	Yes	No	Emphysema	Yes	No
Shortness of Breath	Yes	No	Migraines	Yes	No
Stroke	Yes	No	Anemia	Yes	No
Pacemaker/Defibrillator	Yes	No			
Kidney Disease/Stones	Yes	No	Ulcers	Yes	No
Urinary Tract Infection	Yes	No	Arthritis	Yes	No
Allergies	Yes	No	Osteoporosis	Yes	No
Latex Allergy	Yes	No	Vertigo/Dizziness	Yes	No
Asthma	Yes	No	Alcohol/Drug Abuse	Yes	No
Rheumatic Fever	Yes	No	Mental Disorder	Yes	No
Hepatitis/Jaundice	Yes	No	Depression	Yes	No
Cancer_____	Yes	No	HIV/Aids	Yes	No

Other:_____
_____
_____

Do you now or have you ever smoked?(cigarettes/cigars/pipe/chew/vape) Yes/No How Much_____/Day
Do you exercise regularly when injury free? Yes/No
Do you experience pain, discomfort or shortness of breath with exercise? Yes/No
What are your goals for therapy?_____
Have you had PT/OT or chiropractic treatment this year? Yes/No Where_____
Have you previously had PT for this condition before? Yes/No

MEDICARE PATIENTS ONLY
Are you currently receiving home health services" Yes/No

I attest that this medical history is accurate and complete to the best of my knowledge. I consent to receive physical therapy services that are deemed medically necessary and appropriate by my physical therapist.

Signature_____ Date_____

Therapists Signature_____ Date_____

PAYMENT POLICY

Thank you for choosing Black Hills Physical Therapy as your physical therapy provider. We are committed to providing you with quality care and a positive experience.

Please read our payment policy thoroughly, ask our front office staff any questions you may have and initial/sign in the space provided. A copy will be provided to you if requested.

As a courtesy, we will contact your insurance regarding your physical therapy benefits.

We will provide you with a quote of benefits. Please note that this is not a guarantee of payment. Actual benefits will be determined by your insurance company upon receipt of your claim.

Insurance benefits are a contract between you and your insurance company. Black Hills Physical Therapy is not a party to that contract. You are ultimately responsible for knowing your benefits, acquiring pre-authorization, and payment of copay, deductibles, coinsurances, and any non-covered services such as certain equipment or supplies. Our staff will be happy to assist you with these issues.

Black Hills Physical Therapy will not discount or waive fees found to be patient responsibility for services provided. The insurance industry deems this to be fraudulent practice.

Initial_____/_____

No Show/Cancellation Policy:
Black Hills Physical Therapy respectfully requests a minimum 24 hour notice to cancel an appointment, this will allow us to accommodate other patients.

It is our policy to assess a $60.00 fee for no show appointments in which a call to cancel was not made. These charges are your responsibility and are not covered by insurance.

If you are late for a scheduled appointment, your therapist may not be able to accommodate you out of consideration for our other scheduled patients.

Initial_____/_____

Terms of Agreement:
I have read, understand, and agree to the above Black Hills Physical Therapy policies. I understand that charges not covered by my insurance company such as applicable copayments, coinsurance, deductibles and non-covered items will be my responsibility. I understand that there is a 1% interest fee charged to all account balances over 90 days. In the event that this account is referred to a collection agency, the undersigned agrees to pay all reasonable costs of collection or attorney fees if applicable.

I authorize Black Hills Physical Therapy to submit claims on my behalf and for my insurance benefits to be paid directly to Black Hills Physical Therapy.I understand that this authorization will remain in effect until revoked by me in person. I understand that Black Hills Physical Therapy may disclose protected health information for the purposes of payment, treatment and healthcare operations.

_____ _____

Date Signature of Patient/Legal Guardian/Personal Representative

PATIENT AUTHORIZATION FOR DISCLOSURE

I authorize the person(s) listed below to request and receive information regarding my physical therapy treatment at Black Hills Physical Therapy.

Name_____Relationship_____

Name_____Relationship_____

Name_____Relationship_____

Name_____Relationship_____

_____Date_____

Signature of patient/legal guardian/personal representative

_____

Printed Name

Revised 10/4/2017