PATIENT INFORMATION SHEET

PATIENT: (Please provide your legal name as it appears on your insurance card)

Last Name: _____First Name: _____Middle:_____

Home Address: _____ Apt #_____

City: _____ State: _____ Zip:_____

Mailing Address: _____ Apt #_____

City: _____ State: _____ Zip:_____

Home Phone #: _____Cell Phone#_____ Work Phone #:_____Ext_____

Date of Birth: ___ / ___ / ___ Age: _____ SS#: _____-_____-_____ Gender: M F Martial Status: M S D W

RESPONSIBLE PARTY: Complete this section if you are not the patient but are responsible for the bill.

RP Last Name: _____ First Name: _____ Middle: _____

Home Address: _____ Relationship to Patient_____

City: _____ State: _____ Zip: _____

Home Phone #: _____Cell Phone#_____ Work Phone #:_____Ext_____

Date of Birth: ___ / ___ / ___ Age: _____ SS#: _____-_____-_____ Gender: M F Martial Status: M S D W

SPOUSE or GUARDIAN:
Last Name: _____ First Name: _____ Middle:_____

Employer Name: _____ Work Phone #:_____

Date of Birth: ___ / ___ / ___ SS #: _____Employer:_____

INSURANCE: (please list insurance name and provide a copy of your card to the receptionist)
1st Insurance Company: _____Phone#_____

Insured's Name: _____ ID/Policy #:_____Group#_____

Date of Birth: ___ / ___ / ___ Age: _____ SS#: _____-_____-_____ Gender: M F Martial Status: M S D W

If Medicaid: Which Doctor is your Passport Provider? _____

2nd Insurance Company
Insured's Name: _____ID/Policy #:_____Group#_____
Date of Birth: ___ / ___ / ___ Age: _____ SS#: _____-_____-_____ Gender: M F Martial Status: M S D W
****If Workers Compensation or Motor Vehicle Accident or Personal Injury please complete the attached form****

How did you hear about our clinic?

_____

Authorization[Form 001]

I hereby assign, transfer and set over to Stevensville Physical Therapy and or its individual Therapists, all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

SIGNATURE: (Patient, Parent, Legal Guardian or Responsible Party)

I request services X _____Date_____

_____

STEVENSVILLE PHYSICAL THERAPY

PATIENT MEDICAL HISTORY FORM

Name:_____ Date of Birth:_____ Date:_____

Circle Yes or No

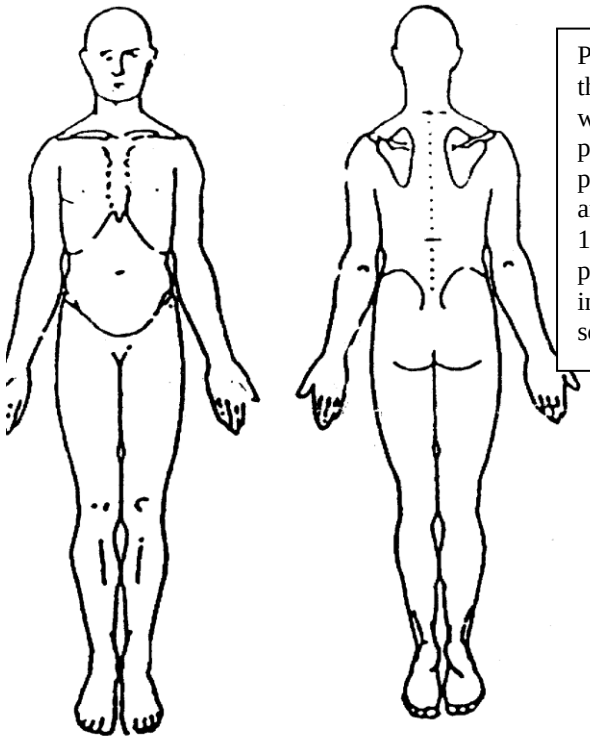
Have you or any immediate family member ever been told you have . . .

	SELF		FAMILY	
Cancer?	Yes	No	Yes	No
Diabetes?	Yes	No	Yes	No
High blood pressure?	Yes	No	Yes	No
Heart disease?	Yes	No	Yes	No
Angina/Chest pain?	Yes	No	Yes	No
Stroke?	Yes	No	Yes	No
Osteoporosis?	Yes	No	Yes	No
Osteoarthritis?	Yes	No	Yes	No
Rheumatoid arthritis?	Yes	No	Yes	No
Bleeding disorders?	Yes	No	Yes	No

In the past 3 months have you had or do experience:

A change in your health?	Yes	No
Nausea/Vomiting?	Yes	No
Fever/Chills/Sweats?	Yes	No
Unexplained weight change?	Yes	No
Numbness or tingling?	Yes	No
Changes in appetite?	Yes	No
Difficulty swallowing?	Yes	No
Changes in bowel/bladder function?	Yes	No
Shortness of breath?	Yes	No
Dizziness?	Yes	No
Upper respiratory infection?	Yes	No
Urinary tract infection?	Yes	No

Please rate your pain over the last 24 hours
Circle your answer…0 1 2 3 4 5 6 7 8 9 10



Please mark on the body chart where you have pain. If you have pain in multiple areas please put a 1 by your worst pain and 2 by less intense pain and so on.

Do you have any allergies to medications?
Yes……No
List _____

List previous surgeries and dates. _____
_____
_____

List medications you are currently using: _____
_____
_____

Do you have a history of:

Allergies/asthma?	Yes	No
Headaches?	Yes	No
Bronchitis?	Yes	No
Kidney disease?	Yes	No
Rheumatic fever?	Yes	No
Ulcers?	Yes	No
Sexually transmitted disease?	Yes	No
Seizures?	Yes	No
Do you have a pacemaker?	Yes	No
Do you have any metal in your body?	Yes	No

Where? _____

Are you currently:

Pregnant?	Yes	No
Depressed?	Yes	No
Under Stress?	Yes	No

Are your symptoms: (check one)
□□ Getting worse □ The same: how long? _____
□□ Improving

How are you able to sleep at night? (check one)
□□ Fine □□ Moderate difficulty
□□ Only w/ Medication

Check all that apply…..
Do you have a problem with…?
□□ Hearing □□ Vision
□□ Speech □□ Communication

Have you consulted an attorney for your current Problem? .....Yes .....No

Preferred learning method….
□□ Verbal □ Written □ Demonstration

Do you, or have you in the past smoked tobacco?
Yes No
If yes, _____ packs X _____ years
Last tobacco use _____

Do you drink alcoholic beverages? ...Yes .....No
If yes, how many drinks do you routinely have per week? _____/week.

Date of last physical examination _____

Stevensville Physical Therapy Payment Policy

Patient Name: _____

Thank you for choosing Stevensville Physical Therapy as your physical therapy provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance:** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. It is also your responsibility to know whether or not pre-authorization is required, and if it is, it is your responsibility to get your treatment pre-authorized. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Self Pay, Copays, and Deductibles:** All copays and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect copays and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your copay at each visit. If you have no insurance, we do expect payment at the time of service unless you have made other arrangements with our billing department. For minor patients, the parent, relative, or other individual escorting the patient is responsible for any payments due at the time of service and for the balance remaining after insurance has processed your claim.

3. **Non-covered Service:** Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare of other insurers. You must pay for these services in full at the time of service.

4. **Proof of Insurance:** All patients must complete our patient information form before seeing a therapist. We must obtain a copy of your current insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the charges you incur.

5. **Claims Submission:** Stevensville Physical Therapy will attempt to obtain payment from your insurance carrier, worker's compensation plan, or motor vehicle insurance. It is our policy to complete an initial claim form and submit it to your carrier. We will assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. If monthly payments are required, please speak with our billing department.

6. **Coverage Changes:** If your insurance changes, please notify us prior to your next visit so we can make the appropriate changes to help you receive your maximum benefits.

7. **Nonpayment:** I understand that I am personally responsible for paying all collection fees associated with my account, including reasonable attorney fees and reasonable collection agency fees. I understand that in the event my account is turned over to a third party collection agency, a collection fee in the amount of up to 50% of my total account balance will be added to my balance and that I am responsible for paying my total account balance plus the collection fee.

8. **Non-Sufficient Funds Checks:** Our policy is to attempt to secure funds from all checks written. If they fail on the first attempt, our bank will automatically send your check through a second time. If it is returned to us we charge our bank fees. The check would need to be covered by cash, credit card, or money order within 5 business days of our notice or it may be presented to our collection agency.

9. **Authorization and Assignment of Benefits:** By signing below I hereby assign, transfer, and set over to Stevensville Physical Therapy, P.C. and/or its individual therapists, all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information required to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

10. **High Deductibles:** Patients who have a deductible of $1000.00 or more are asked to pay $75.00 at each physical therapy visit. This payment will be applied toward charges for each date of service. Please note that the patient responsibility for each visit will be determined by benefits of the insurance plan and will likely exceed $75.00. A statement for the remaining account balance will be sent at the beginning of each month. Please discuss your care with your physical therapist. For available options regarding your account please contact our Billing Department for assistance.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for reviewing our payment policy. Please let us know if you have any questions or concerns.

I have read and understand this payment policy, including the Notice of Privacy Practices and the Assignment of Benefits, and I agree to abide by its terms:

_____ _____

Signature of Patient or Responsible Party **Date**

PATIENTS WITHOUT INSURANCE

Self/Direct-Pay: By signing below I state that I or the minor patient ***DO NOT*** have health insurance and will be responsible for services rendered here at Stevensville Physical Therapy, P.C. I agree to pay Stevensville Physical Therapy P.C. the full and entire amount of treatment given to me or to the above named patient at each visit.

_____ _____

Signature of Patient or Responsible Party **Date**

HIPAA - Notice of Privacy Practices

Congress passed the Health Insurance Portability and Accountability Act, or HIPAA, in 1996. Its primary purpose is to ensure that people who change jobs cannot be denied health insurance in a new job because of a pre-existing health condition. The law also established minimum standards of privacy and security to ensure that sensitive information about individuals' health would remain confidential.

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Hamilton Physical Therapy and Sports Rehabilitation Center, P.C.'s / Stevensville Physical Therapy's Notice of Privacy Practices (NPP). I understand that if I have any questions regarding the Notice or my privacy rights, I can contact the clinic's HR department at (406) 375-9034; or by email at hradmin@hamiltonpt.com.

I acknowledge that I have been given an opportunity to review the NPP, and that it is available in hard copy upon request. I also understand that the NPP is available on the practice's website at www.stevipt.com which will re-direct you to www.hamiltonpt.com.

Patient or Legal Guardian: _____
(Signature - Legal guardians *must* sign for minors)

Patient or Legal Guardian: _____
(Printed Name)

Relationship: _____ **Date: _____**

Please list the individuals and their information that you give permission for us to speak with regarding your treatment and/or account. This includes, but is not limited to, your spouse, the mother or father of a child, significant other of the patient, attorney, etc. You are not obligated fill in the portion below if you choose not to.

Please note that if the appropriate boxes are not checked for everyone listed below, we legally cannot speak with said individuals regarding your appointments and/or account. Thank you for your understanding.

EMERGENCY CONTACT:

Full Name:_____ DOB:_____

Relation to Patient: _____ Phone #: _____

☐ Okay to release information pertaining to my treatments/records (including any appointments you may have).

☐ Okay to release information pertaining to my account regarding all billing inquiries.

Full Name:_____ DOB:_____

Relationship to Patient:_____ Phone #:_____

☐ Okay to release information pertaining to my treatments/records (including any appointments you may have).

☐ Okay to release information pertaining to my account regarding all billing inquiries.

Full Name:_____ DOB:_____

Relationship to Patient:_____ Phone #:_____

☐ Okay to release information pertaining to my treatments/records (including any appointments you may have).

☐ Okay to release information pertaining to my account regarding all billing inquiries.

Our goal is to provide patients with an excellent therapy experience. We strive to provide the best possible care available. As part of our plan, we have formulated this policy to allow for maximal one on one time with our therapists.

CANCELLATION POLICY

A cancellation is defined as patient giving notice to our office that they need to cancel less than 24 hours prior to their appointment time. If you have 2 cancellations, you will be taken off the schedule. At that time, you will need to call on the day you wish to be seen and we will accommodate you with an appointment if we have availability. This may be with a different therapist than your primary therapist if that is our only availability. Following 3 treatments scheduled using the previously mentioned method with no cancellations, you will again be able to schedule in advance. No-show appointments count towards this policy.

NO SHOW POLICY

A No-show is defined as not appearing for your scheduled appointment or not calling to cancel prior to your scheduled time. If you have 2 No Show appointments, you will be taken off the schedule. At that time, you will need to call on the day you wish to be seen and we will accommodate you with an appointment if we have availability. This may be with a different therapist than your primary therapist if that is our only availability. Following 3 treatments scheduled using the previously mentioned method with no "No-show" appointments, you will again be able to schedule in advance.

Patient was offered a copy of this policy on date signed. Stevensville Physical Therapy has the right to modify this policy at any time for any reason without notice.

Patient Signature Date