NEW PATIENT INFORMATION FORM

(Please Print and write name how it is shown on your insurance card)

PATIENT INFORMATION

Patient's First name: MI: Last Name:			Date of Birth: / /
Social Security #:	❑ Male ❑ Female		Patient Nickname:
Street address:			
City:	State:	Zip Code:	Primary Number:
Occupation: Employer Name:	Email address:		Secondary Number:

Referred to clinic by (please check one box):
❑ Dr._____ ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Emergency Contact Name and no:

INSURANCE INFORMATION

Primary Insurance:	Secondary Insurance:
Insured's Name:	Insured's Name:
Insured's Birth Date:	Insured's Birth Date:
Insured's Gender:	Insured's Gender:
Relation to Insured:	Relation to Insured:

ACCIDENT DETAILS- PLEASE COMPLETE IF THIS VISIT IS DUE TO INJURY

Employment related: ❑ Yes ❑ No	Accident related: ❑ Auto ❑ Yes ❑ No	Date of first symptom or accident: / /

Give details of accident:

I authorize the release of any medical or other information necessary to process insurance claims.
I authorize payment of medical benefits directly to this practice for the services rendered.

_____

Patient/Guardian signature Date

GENERAL MEDICAL HISTORY FORM

Name: _____ Age _____ SSN: _____Date:_____

Contact Numbers (Home/Work): _____EMAIL:_____
Emergency Contact & Number:_____
Referring Physician: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS.

1. Have you received a therapy assessment or treatment within the current year? Y N
2. Are you currently under Home Health Care or Hospice? Y N
3. Have you had surgery for this injury within the last 8 weeks? Y N
4. Have you had a cast removed from the injured body part within the last 2 weeks? Y N
5. Is this injury the result of a workplace accident? Y N
6. Is this injury the result of a motor vehicle accident that has occurred within the last 90 days? Y N

TO RULE OUT CONTRAINDICATIONS TO TREATMENT, MARK AN "X" IN THE APPROPRIATE BOX IF YOU HAVE EVER SUFFERED ANY OF THE FOLLOWING HEALTH PROBLEMS.

__Seizures/stroke __Bleeding problems __Diabetes __Osteoporosis __Blood clots
__Blood pressure __Chest pain/angina __Cancer __Anemia __HIV

INDICATE WITH AN "X" WHICH OF THE SYMPTOMS BELOW YOU PRESENTLY SUFFER FROM.

__Shortness of breath __Nausea/vomiting __Numb/tingling
__Difficulty swallowing __Changes in bowel function __Changes in bladder function
__Increased pain at night __Fever/chills/sweats __Dizziness

HISTORY OF PRESENT INJURY

What part of your body is presently injured?_____
What Medications are you currently taking?_____
Pain Medications? Y N Please List _____
Anti-Inflammatories? Y N Please List _____
When/How were you injured? _____
How were you referred to us? __Physician __Friend, if so whom?_____
__Print Ad __Previous experience with clinicians

ACKNOWLEDGEMENT

I have completed this form to the best of my knowledge and ability.

Patient's Signature:_____ Date _____

Cancellation & No Show Fee Policy

Due to high patient demand, and limited availability of appointments we have instituted a $25.00 no show/cancellation less than 24 hours fee.

Each time a patient misses an appointment without provided proper notice, another patient is prevented from receiving care. We reserve the right to charge for these occurrences if in fact you've canceled in less than 24 hours or no showed for that appointment.

By signing this agreement, you the patient are attesting that you understand that if you fail to give a minimum of 24 hours notice of cancellation for any of our services, you will be assessed a no-show/cancellation less than 24 hours fee in the amount of $25.00 per each occurrence. You are also attesting that you understand that this charge will be billed directly to you, not your insurance company.

_____

Patient Signature Date:

_____

Patient Name (Printed)

Financial Policy & Consent form

Thank you for choosing DASH Physical Therapy your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement we require you to read and sign prior to any treatment.

REGARDING INSURANCE

We will gladly bill your insurance company directly. Your contract for health insurance is between you and your insurance company. We are not a party to that contract. The physical therapy services that you receive and the bill, is an agreement between you and DASH Physical Therapy. *It is ultimately your responsibility to see that your physical therapy bill is paid in full.* Agreements with insurance companies vary greatly and it is your responsibility to know what their portion is and what is yours. Any remaining money unpaid by your insurance company will be your responsibility to pay in a timely manner.

REGARDING INSURANCE PLANS WHERE WEARE A PARTICIPATING PROVIDER:

All co-pays and deductibles are due when services are rendered.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Please be aware that some services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurances.

HIPAA

HIPAA NOTICE OF PRIVACY PRACTICES are available on file for your perusal.

CONSENT FOR CARE & TREATMENT

I, the undersigned, do hereby agree and give my consent for Dash Physical Therapy to furnish medical care and treatment considered necessary and proper in diagnosing or treating his/her physical and mental condition.

BENEFIT ASSIGNMENT/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 payers to DASH. 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.

I have read and understand this *Financial Policy*. I agree and acknowledge DASH Physical Therapy *HIPAA NOTICE OF PRIVACY PRACTICES,* Consent for Care & Treatment, and Benefit Assignment/Release of Information.

Patient/Guardian/Responsible Party_____

HIPPA CONSENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple healthcare Providers who may be involved in that treatment directly and indirectly.

Obtain payment from third-party payers.

Conduct normal healthcare operations such as quality assessments and physicians certifications.

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 this Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name:_____
Signature of Patient or Responsible Party:_____
Relationship to Patient:_____ Date:_____