GATEWAY PHYSICAL THERAPY AND WELLNESS

Medical History

Name: _____ Date: _____

Height: _____ Weight: _____

1. HAVE YOU EVER HAD ANY OF THE FOLLOWING PROBLEMS?

___ Diabetes	___ Allergies	___Ear/Nose Throat
___Nerve/Neurological	___Arthritis	___Swallowing
___Cardiac/Heart/Pacemaker	___Joint Replacement	___Coughing
___Circulatory Vascular	___Fractures	___Vision
(clots/phlebitis)	___Strokes	___ Speech/Language
___Cancer/Tumor	___Asthma	___Memory
___Parkinson's	___Back/Neck Injury	___Hearing
___High Blood Pressure	___Seizures	___Other

COMMENTS: _____

2. Do you presently have any of the following conditions? Pregnancy, Hepatitis, TB, Contagious or Infectious Disease?
____ YES ____ NO

3. What is the condition for which your doctor referred you to therapy? _____
_____

4. Are you currently receiving any other treatment for this condition? _____
_____

5. List any recent hospitalizations and reason: _____

6. List any recent tests pertaining to current problem (X-Rays, MRI, etc.): _____
_____

7. List medications and dosages you are currently taking: _____
_____

8. Have you ever had therapy in the past? _____

9. Has your doctor imposed any restrictions on your activities? _____
_____

10. What are your goals and expectations for treatment? _____
_____

Signature _____ **Date:** _____

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Name (Last)_____(First)_____(Middle Initial)____

Address (same address that insurance has on file) _____

City:_____ ____State:_____ Zip Code:_____

Home#_____ Cell #_____ Work #_____

Please indicate which phone line we can leave a message on_____

Email:_____ DOB_____

Primary Care Physician Name_____ Phone#_____

Emergency Contact:_____ Relationship _____ Phone #_____

Please list the people that we can share your information with and indicate what information may be given in the event of an emergency.

Name	Medical	Billing	Both
_____	_____	_____	_____
_____	_____	_____	_____

Appointment reminder consent: Please select one if you chose:

- o Gateway Physical Therapy may send email messages to confirm upcoming appointments
- o Gateway Physical Therapy may send cell phone text messages to confirm upcoming appointments to phone #_____

I recognize that text messaging rates may apply

In order to receive text messages we must know what cell phone carrier you have, please indicate your carrier below:

___ALL Tel
___AT & T
___Boost Mobil
___Cingular
___Cricket Wireless
___Metro PCS
___Nextel
___Qwest
___Sprint PCS
___T Mobile
___US Cellular
___Virgin Mobile
___ Verizon

Signature_____ Date: _____

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PLEASE READ AND SIGN THE AUTHORIZATION BELOW

Our office is committed to providing you with the best possible care. While filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date services are rendered. **We make every effort to provide you with accurate coverage/co-pay information; however, we are not responsible for misinformation given by your insurance company. Therefore it is your responsibility to have full knowledge of your specific benefits.**

I agree to pay my co-payments/deductibles as services are rendered:

My policy has a co-payment of $ _____ per visit which is due at the time of each visit.

My policy has a deductible of $ _____ and _____ % co-insurance. **Company policy requires that you make a payment each visit towards your deductible/co-insurance. If for any reason a balance is outstanding on my account, I agree to pay promptly upon receipt of my statement.**

There will be a $25.00 fee for all returned checks and a late fee of $10.00 for every 30 days payment is not received.

I understand that it is my responsibility to be fully knowledgeable of my insurance benefits. It is also my responsibility to inform Gateway Physical Therapy and Wellness as soon as possible of any changes to my insurance coverage during my course of physical therapy. Failure to do so may result in additional financial responsibility owed by me due to insurance denial, based upon claims that are not filed in a timely fashion or filed with inaccurate data.

Patient or Guardian Agreement:

- o I authorize release of information requested by my insurance plan for payment
- o I understand that I am responsible for any balance due

Cancellation Policy

If you fail to keep your scheduled appointment, or do not cancel within 24 hours, we reserve the right to charge the patient $65.00. I understand that Gateway Physical Therapy and Wellness has the right to end my plan of care due to continued absenteeism without notice.

Signature: _____ Date: _____

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NOTICE AND ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

1. Patient Consent to Treat
I, the undersigned patient, consent to such treatment procedures as are deemed necessary by the provider, including those which are in addition to or different from those initially contemplated, and which are deemed necessary or advisable by the provider in the course of treatment.

2. Patient Consent for Use and Disclosure of Protected Health Information (PHI)
I, the undersigned patient, give my consent to the provider entity and its agents to use or disclose my protected health information (PHI) to carry out treatment, payment, or health care operations. These individuals and entities can release, use or disclose my PHI to other health care personnel including, but not limited to, physicians, certified registered nurse anesthetists, anesthesia assistants, nursing staff, nurse practitioners, physicians assistants, child life specialists, physical therapists, respiratory therapists, X-ray personnel, audiologists, students in each of the above disciplines, and other such entities or persons as are deemed related to treatment, or payment, and health care operations, as determined in the sole discretion of the provider, his/her practice group, and their respective agents.

3. Permission to Release Medical Records to Providers
If another provider who is involved with my treatment, payment, or health care operations relating to me requests my medical records, I consent to the release of my entire medical record maintained by the provider to those other providers

4. Permission to Release Billing Information Over the Telephone
I agree, as part of this consent for payment operation, that the provider, its groups, and their billing personnel, billing agents, or management company can disclose billing formation to any person who called the provider with a billing question after the provider inquires as to the identity of the calling person provides my correct social security number and health care number.

5. Permission to Call and Leave Voice Mail Message
I agree that the provider or its agents or representatives may call and leave a voice mail message at my home or other number I provide them regarding medical appointments, billing or payment issues, or other information related to treatment, payment or health care operations.

6. Permission to Discuss Protected Health Information with Third Persons
I agree that the provider may discuss my PHI with any person who accompanies me to a visit or procedure or is present with me when the provider is present. The provider may rightly assume that if another person is with me, I have no objection to disclosure of my PHI to that person. I also agree that the provider may discuss my PHI with any person who identifies him or herself as active in my mental, physical, emotional, or spiritual care, including, but not limited to family, friends, clergy, and patient advocates. I also agree that the provider, his/her practice group, and their agents may disclose my PHI to employers who arrange and pay, directly or indirectly, for my medical treatment.

7. Permission to Discuss Protect Health Information Regarding Minors
I agree that the provider, his/her practice group, and their agents may discuss my child's PHI with the person accompanying the child. I agree that the provider may discuss PHI with both natural parents and stepparents. I acknowledge that state law may grant my child certain privacy rights regarding the child's PHI, and that I have no right to receive this information.

8. Permission to Discuss Protect Health Information With Public Agencies
I agree the provider, his/her practice group, and their agents may, upon request by the following entities, disclose my PHI to public health agencies, law enforcement, and the FDA.

9. Acknowledgement of Receipt of Notice of Privacy Practices
I acknowledge that I have received this Notice of Privacy Practices which sets forth this provider's privacy practices and my rights regarding privacy of my PHI.

_____ _____

Patient Signature Date

_____

Print Name