Premier Physical Therapy

PATIENT INFORMATION FORM

Patient Name_____ **Date of Birth**_____
(first) (Middle Initial) (Last)

Gender (circle one): Male Female Social Security # _____

Mailing Address_____
(number and street) (City) (State) (Zip)

Phone #s: Home_____ Work _____ Cell_____

If Patient is Under 18 Please complete this box:

Guarantor Name _____ Date of Birth _____

Social Security # _____ Relationship to patient _____

Address (if different than patient) _____

Phone #'s: Home _____ Work _____ Cell _____

How did you hear about Premier PT? **Friend/Relative** **Dr. Referral** **Radio/Newspaper**
Social Media/Website **Other:**_____

Referring Physician (*required*)_____ **Date of Injury**_____

Location of injury/pain: _____

Description of injury/pain: _____

_____

_____

Intensity of symptoms:
Slight 1 2 3 4 5 6 7 8 9 10 Severe
(Circle a number to describe your symptoms)

Frequency of symptoms:
Rare 1 2 3 4 5 6 7 8 9 10 Constant
(Circle a number to describe your symptoms)

What have you done to treat injury/pain: _____

_____

_____ _____

Signature **Date**

Premier Physical Therapy

MEDICARE PATIENT INFORMATION

This information MUST be completed by Medicare patients:

- **Have you had any Out Patient Physical Therapy services this year?**

  (Please Circle One): Yes No

  Patient Weight: _____lbs. **Patient Height**: ____feet _____inches

- **Patient Pain Scale, circle one** (10 = emergency room pain 0 = no pain):

  1 2 3 4 5 6 7 8 9 10

- **Have you fallen in the past 6 months (circle one):** No Yes Frequency:_____

- **Medication List (include medicine strength, dosage and frequency you take the medication):**

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Premier Physical Therapy

INSURANCE INFORMATION

Please Complete Insurance Information AND Sign Bottom of Form

Type of coverage (circle one): Self-Pay Health Insur Auto Insur Workers' Comp other:_____

Primary Insurance: **Legible copy of front and back of card will suffice OR:**

Insurance Name _____

Address _____

Phone_____

Subscriber name_____

ID or Claim #_____ Group#_____

Secondary Insurance: **Legible copy of front and back of card will suffice OR:**

Insurance Name _____

Address _____

Phone_____

Subscriber name_____

ID or Claim #_____ Group#_____

For Auto Injury:

Attorney Name _____

Attorney Address: _____

Attorney Phone Number:_____

For Workers' Comp:

Work Comp Company Name:_____

Adjustor Name: _____

Adjustor phone number:_____

- I authorize *Premier Physical Therapy* to release any medical information necessary to process my claim to my insurance company or to any other concerned third party.
- I authorize my insurance company or any other concerned third party to make payment directly to *Premier Physical Therapy*. Medical liens are very likely to be issued to all concerned third parties in various accidental injury situations.
- **I understand that I am responsible for all charges incurred regardless of insurance or third party liability, should they fail to reimburse.**

_____ _____

Signature **Date**

Premier Physical Therapy

Financial Policy

In order to provide the best quality healthcare for our patients and keep healthcare costs at a minimum, *Premier Physical Therapy* has implemented a financial policy. Please read it carefully then sign and date the form to ensure your visits with us always meet your best expectations.

We are pleased to bill third party insurance companies for all of our patients and will strive to be an in-network provider for as many insurance companies as possible. **Eligibility, coverage, and prior authorizations are the patient's responsibility.** We are pleased to assist our patients with any of these issues upon the patient's request to our **billing office at 406-543-1546**.

Patients should bring (an) insurance card(s) to each appointment for verification. Co-payments are due at the time of check-in for the appointment. If, for any reason, a patient does not have an insurance card or co-payment, a patient may be asked to reschedule the appointment. Patients are asked to notify our office of an appointment cancellation 24-hours in advance so that we may accommodate the needs of all of our patients.

Patients who do not have insurance, should either make payment in full on the date of service or begin to make payments according to an agreed upon payment plan for services rendered with cash or check, on date of service.

Motor Vehicle claims are handled the same as self-pay accounts. We will bill auto insurance and attorneys, but we cannot wait for litigation. The patient will be expected to make payment within 30 days.

On occasion, overpayments will occur. We will make every effort to refund the appropriate party in a timely manner.

Co-payments are due on the date of service. The insurance company is billed and if there is any patient responsibility remaining, an invoice will be sent to the patient. Payment is expected within 30 days of sent invoice. Payment plans may be established by contacting our billing office at the number listed below. Please keep your contact information current with our office. After 60 days, unpaid accounts could be sent to a third party for collection. *Premier Physical Therapy* is dedicated to serving your healthcare needs and we are willing to work with patients' individual circumstances within the bounds of the financial policy.

_____ _____

Signature **Date**

Please call our billing office at (406) 543-1546 with any questions regarding your account.

Premier Physical Therapy

Notice of Privacy Practices

This Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient, and our common practices in dealing with patient health information.

Uses and Disclosures of Health Information:
We will use and disclose your health information in order to treat you or to assist other healthcare providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other healthcare providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization:
Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization:
In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your healthcare
- For certain limited research purposes
- For purpose of health and safety
- To government agencies for purposes of their audits, investigations, and oversight activities
- To government authorities to prevent child abuse and domestic violence
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders
- When required by court orders, search warrants, subpoenas, and otherwise required by law

Patient Rights:
As our patient, you have the following rights:

- To have access to and/or copies of your health information
- To receive an account of certain disclosures we have made of your health information
- To request restrictions as to how your health information is used or disclosed
- To request that we communicate with you in confidence
- To request that we amend your health information
- To receive notice of our privacy practices

Please contact us with any questions, concerns, or complaints regarding our privacy practices.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understand the Notice.

_____

Patient Name (please print)

_____

Parent or Authorized Representative (if applicable) (please print)

_____ _____

Signature Date