BEEBE PHYSICAL THERAPY

PATIENT INFORMATION FORM

Patient Name:____
First Middle Last Marital Status

DOB:__________________ Age:________ SS#_______________________ MALE or FEMALE

Address:____
City Sate Zip

Contact phone #:__________________________________ Can we leave a Voice Mail? Yes or No

Cell Phone#__________________________________ Cell phone company________________

How did you hear about Beebe Physical Therapy? (friend, doctor, location, website)________________

Referring doctor:____

Primary Insurance Name:____

Primary Insurance ID#:____

Primary Insurance sponsor name and DOB:____

Secondary Insurance Name:____

Secondary Insurance ID#:____

Secondary Insurance sponsor name and DOB:____

In an effort to comply with current HIPAA(Health Insurance Portability Accountability Act) regulations, we need you to complete the following information. Please list any person other than your doctor with whom we may discuss your private health information or financial matters:

Name:__________________________Relationship__________________Phone #:______________________

Name:__________________________Relationship__________________Phone #:______________________

Emergency contact:__________________________________phone:________________________________

If your primary insurance is Medicare: Please be advised that MEDICARE WILL NOT PAY for outpatient physical therapy services ***IF*** you are receiving any home health services (such as: assistance with cooking, cleaning, medication ect.) As of January 1, 2019, Medicare has a limit for physical therapy services of $2040.00 per calendar year, which will end December 31, 2019. In the event you reach this limit, the following options are available to you. Please mark your choice. Discontinue_________ or Continue__________ or N/A__________

I authorize my insurance benefits be paid directly to Beebe Physical Therapy. I understand that I am financially responsible for any balance. I also authorize Beebe Physical Therapy to release any information required to process my claims.

____

PATIENT SIGNATURE/GUARDIAN SIGNATURE DATE

BEEBE PHYSICAL THERAPY

Briefly describe your work activity and/or occupation:________________________________

Briefly describe your current symptoms/injury/pain:________________________________

____

When did your symptoms begin:____________________Surgery Date:____________or N/A

What caused your symptoms/injury:________________________________

Have you fallen in the last 12 months?________ If so, did you have an injury?____________

Are you pregnant?______Do you have a history of cancer?______ Do you have a pacemaker?_____

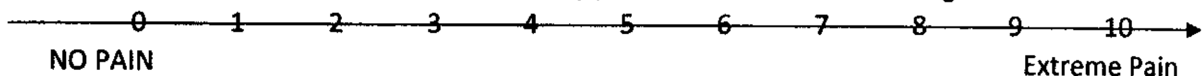
Are you taking any seizure medication?_____If so, please list medication name______________

Are you taking any medications that might affect your lungs, heart, consciousness, or general well-being while participating in therapy?_____If so, please list medication__________________

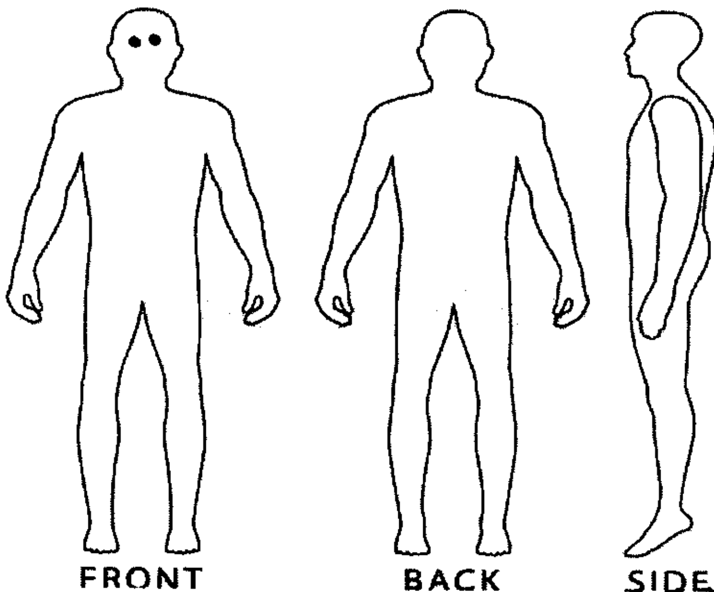
Are you currently taking any medication? If so, please list any prescription, over-the- counter, herbals, vitamins/mineral/dietary supplements in the box below. If you have a list written down, we can make a copy.

Prescription Name	Dosage	Frequency	Route

Please circle your current pain level for the body part for which we are treating.



Please mark the body part where you are experiencing pain



BEEBE PHYSICAL THERAPY

Cancellation Policy:

The therapist and staff of Beebe Physical Therapy are glad you are here. You are the reason this phyiscal therapy practice exists, and we promise to never forget that fact! Your successful rehabilitation is our top priority. To achieve the best possible outcome, we and/or your doctor have recommended a particular treatment schedule. To attain these results, it is very important that you attend your therapy sessions as scheduled.

If you are unable to keep a scheduled appointment, please let us know 2 hours in advance. A NO SHOW is when a patient fails to keep a scheduled appointment and does not call before the appointment to cancel. We understand that there may be issues beyond your control, and we want to be understanding of special circumstances.

1. If you are more than 15 minutes late, your appointment will more than likely need to be rescheduled due to conflicting appointments and a no show will be recorded for that day. If you are aware that you are going to be late, please call the office and let us know as soon as possible.

2. Worker's Compensation and Personal Injury patient's documents of any missed or cancelled appointments are forwarded to your case manager and primary care doctor. This could jeopardize your claim and prolong or stop any entitled benefits.

3. After having three CANCELS in a row, you may be placed on a same day scheduling policy for your treatment, which would not allow you to schedule any appointments in advance. Three consecutive no shows will result in immediate discharge.

We appreciate the opportunity to provide you with uncompromising care. Thank you for your consideration of our staff and other patients.

Consent for Purposes of Treatment, Payment, and Health Care Operations:

I consent to the use or disclosure of my Protected Health Information(PHI) by Beebe Physical Therapy for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of Beebe Physical Therapy. I understand that diagnosis or treatment of me by Beebe Physical Therapy may be conditioned upon my consent as evidence by my signature on this document. If you would like a full copy of this consent, they are available upon request.

PATIENT SIGNATURE/GUARDIAN SIGANTURE DATE

Office use only:

Reviewed By: