MyoFit Physical Therapy CLINIC

PHYSICAL THERAPY ♦ WELLNESS SERVICES ♦ PAIN MANAGEMENT ♦ SPORTS ENHANCEMENT

PATIENT INFORMATION FORM

Reset Entire Form

Patient Information

Reset Section

Last Name _____ First Name _____ SSN _____

Date of Birth _____ Gender _____ Marital Status _____

Address _____

City _____ State _____ Zip _____

Home Phone # _____ Work Phone # _____ Cell Phone # _____

Email _____

Emergency Contact

Reset Section

Last Name _____ First Name _____

Relationship _____ Phone # _____

Employer

Reset Section

Name _____ Phone # _____

Address _____

City _____ State _____ Zip _____

Problem

Reset Section

Problem Description _____ Date of Injury _____ Last Physician Visit _____

Referred by _____

Notes/Comments _____

Primary Insurance

Reset Section

Insurance Company _____ ID # _____ Group # _____

Subscriber Name _____ Subscriber Date of Birth _____ Relationship _____

If Medicare: Have you been on Home Health Services _____ Discharge Date _____

If Workers' Compensation: Paying Agency/State _____ Case # _____

Case Manager _____ Phone # _____

Date of Injury _____ Employer at the Time of Injury _____

Supervisor _____ Employer Phone # _____

Employer Address _____ Employer City, State, Zip _____

Secondary Insurance

Reset Section

Insurance Company _____ ID # _____ Group # _____

Subscriber Name _____ Subscriber Date of Birth _____ Relationship _____

If Medicare: Have you been on Home Health Services _____ Discharge Date _____

Signature: _____ Date: _____

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PATIENT INFORMATION FORM

Patient Name: _____ Patient Case: _____

Referring Physician: _____ Primary Physician: _____

Date of Injury/Onset Date: _____

Have you had surgery for this injury? Yes ☐ No ☐ If yes, when? _____

Type of Surgery? _____

Have you had any of the following services for this injury?

Chiropractor	Y ☐	N ☐	CT Scan	Y ☐	N ☐
Message Therapy	Y ☐	N ☐	MRI	Y ☐	N ☐
Mylogram	Y ☐	N ☐	Neurologist	Y ☐	N ☐
Physical Therapy	Y ☐	N ☐	Orthopedist	Y ☐	N ☐
Occupational Therapy	Y ☐	N ☐	Podiatrist	Y ☐	N ☐
Emergency Room Care	Y ☐	N ☐	X-Rays	Y ☐	N ☐
EMG	Y ☐	N ☐	Other: _____	Y ☐	N ☐

Current Level of pain: (0=No Pain, 10 Worst Level)

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Are you currently taking any prescription or non-prescription medications: Yes ☐ No ☐ If yes, please list:

_____

_____

Do you have or have you ever had any of the following?

Asthma, Emphysema	Y ☐	N ☐	Severe or Frequent Headaches	Y ☐	N ☐
Shortness of Breath/Chest Pain	Y ☐	N ☐	Vision or Hearing Difficulties	Y ☐	N ☐
Coronary Heart Disease	Y ☐	N ☐	Numbness or Tingling	Y ☐	N ☐
Pacemaker	Y ☐	N ☐	Dizziness or fainting	Y ☐	N ☐
Heart Attack/Surgery	Y ☐	N ☐	Bowel or Bladder problems	Y ☐	N ☐
Stroke/TIA	Y ☐	N ☐	Weakness	Y ☐	N ☐
Congestive Heart Disease	Y ☐	N ☐	Weight Loss/Energy Loss	Y ☐	N ☐
Blood Clot	Y ☐	N ☐	Hernia	Y ☐	N ☐
Epilepsy/Seizures	Y ☐	N ☐	Varicose Veins	Y ☐	N ☐
Thyroid Disease	Y ☐	N ☐	Allergies	Y ☐	N ☐
Anemia	Y ☐	N ☐	Any pins or metal implants	Y ☐	N ☐
Infectious Disease	Y ☐	N ☐	Joint Replacement Surgery	Y ☐	N ☐
Diabetes	Y ☐	N ☐	Neck Injury/Surgery	Y ☐	N ☐
Cancer/Chemotherapy/Radiation	Y ☐	N ☐	Elbow/Hand Injury/Surgery	Y ☐	N ☐
Arthritis	Y ☐	N ☐	Back Injury/Surgery	Y ☐	N ☐
Osteoporosis	Y ☐	N ☐	Knee Injury/Surgery	Y ☐	N ☐
Gout	Y ☐	N ☐	Leg/Ankle/Foot Injury/Surgery	Y ☐	N ☐
Sleeping Problems/Difficulties	Y ☐	N ☐	Are you Pregnant?	Y ☐	N ☐
Emotional/Psychological problems	Y ☐	N ☐	Do you Smoke?	Y ☐	N ☐

List any other information that would assist us in your care. _____

_____

What are your Rehabilitation expectations/goals while in this program? _____

_____

Signature: _____ Date: _____

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HIPPA CONSENT

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I understand that, under Health Insurance Portability and Accountability act of 1996 (HIPPA), 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 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 the notice.

I understand that I may request in writing that MyoFit Clinic restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand MyoFit Clinic is not required to agree to my requested restriction, but if they 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 MyoFit Clinic has taken action relying on this consent.

Patient Name (Please Print): _____

Signature of Patient or Representative: _____

Relationship to Patient: _____ Date: _____

Financial Policy Agreement/Assignment of Insurance Benefits

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We accept most insurance companies; however, we may not be in network with them. Our office staff will call and verify all insurance coverage that you may have. You will be contacted by one of our staff members to give you an estimate of what each visit will cost. This amount is just an estimate and the actual amount due may differ. Although we strive to obtain the most accurate coverage information, we are occasionally given incorrect information. If this occurs, you are responsible for any difference in what was quoted by your insurance company and what was actually paid. We recommend that you call your insurance carrier as well, so that you can better understand your benefits.

If your insurance requires you to have a referral or authorization for physical therapy, please verify with the front desk that a current referral or authorization is on file. We will do everything in our power to ensure that we have the necessary referrals or authorizations; however, it is ultimately your responsibility to verify that all visits are covered by a referral or authorization. Any charges incurred that are not covered by your insurance become your responsibility.

All payments of estimated portions are expected at the time of service unless other arrangements have been made. Cancellation and No Show fees are your responsibility to cover and should be paid at the following date of service. No insurance company including Worker's Compensation and Medicaid will cover those fees.

I do herby authorize my insurance carrier(s) to pay directly to MyoFit Clinic the insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for any charges transferred to me by my insurance carrier(s), including co-pay, co-insurance and/or deductible amounts as well as those not covered by my insurance. I agree to pay all attorney fees, court costs, filing fees including commissions that may be assessed to me by any collection agency retained to pursue such matters.

Signature of Patient or Guardian: _____ Date: _____

Consent for Treatment

I do herby agree to give my consent for MyoFit Clinic to furnish medical care and treatment for _____ considered necessary and proper in diagnosing or treating my/his/her Physical condition.

Signature of Patient or Guardian: _____ Date: _____

Attendance Policy

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We strive to provide our patients with the utmost professionalism and excellence of service. Our commitment to your well-being and progression toward goals is something we at MyoFit Clinic take very seriously. Because we care so much about you, we realize that it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need to receive and to the actions we ask you to do. Your adherence to the recommended number of treatments is a vital component of your progress; therefore, we have certain rules that need to be followed to ensure the most optimum results. We expect you to keep all of your appointments. We will write down your appointment times and dates for you so you do not forget. If requested, reminders can be made the day before your scheduled appointment.

With the exception of SERIOUS emergencies, it is expected that you will keep all of your appointments. **If you need to reschedule an appointment, we require a 24 hour advance notice.** In such a case, please call our office to make arrangements for a make-up appointment. **In an instance of a same day cancellation, or a no show to a scheduled appointment, we reserve the right to charge you a $20 fee.**

In instances of repeated noncompliance with your scheduled visits, we also reserve the right to discontinue care. We will inform your physician, that your services have been discontinued due to noncompliance with prescribed rehabilitation orders.

In an effort to provide the highest standard of care to all of our patients and to protect privacy, we request that children attend therapy sessions only if it is absolutely necessary. During these times we kindly ask that you keep your child close to you at all times. **MyoFit Clinic reserves the right to discontinue treatment should your child become disruptive, distracting, or their behavior exceeds your ability to monitor them. MyoFit Clinic is not responsible for any damages and not liable for any injury caused by your children.**

We appreciate you greatly as our patient and strive to accomplish wonderful results and success for you!

I have read and understand the above policy.

Signature: _____ Date: _____

APPOINTMENT REMINDER CONSENT

Reset Page

Complete this form and sign below to give your permission for MyoFit Clinic to provide automatic appointment reminder service by email or by cell phone text message.

Step One: Select One Option Below

- Email messages may be sent to confirm my upcoming appointments to the following email address: _____
- Cell phone text messages may be sent to confirm my upcoming appointments to the following cell phone number **(I recognize that normal text messaging rates may apply.)**: _____

Step Two: If you would like text messages instead of email reminders, please indicate your Cell phone Carrier.

We cannot set your account up to send text message reminders without knowing your cell phone carrier. Please indicate your carrier below, if you would like text message reminders:

- ALLTel ☐
- AT&T ☐
- Boost Mobile ☐
- Cingular ☐
- MetroPCS ☐
- Nextel ☐
- Sprint PCS ☐
- T Mobile ☐
- Verizon ☐
- Virgin Mobile ☐

Signature of Patient or Guardian: _____ Date: _____