MRPT Physical Therapy, LLC

Patient Information Form (*Please fill in form completely)* **Date**:_______________

Name:____________________________ Date of Birth: ___________ SSN:_________________________

Address: ________________________________ Apt #: _____ City: ______ State: _____ Zip:__________

Phone numbers: Home _________________________ Work: ________________________________

Cell: ____ E Mail: ______________________________

Emergency Contact: Name: ______________________ Phone: __________________________________

Primary Insurance: ☐ United ☐ Cigna ☐ Medicare ☐ Aetna ☐ Oxford
☐ Healthnet ☐ Cash (No Ins) ☐ Other______________________

Secondary Insurance: ☐ AARP ☐ United ☐ Other______________________

Reason for Visit: ☐ Gradual Problem ☐ Sports Injury ☐ Post Surgical
☐ Auto Accident ☐ Employment accident ☐ Date of Accident ___________

Referral Information:

Who referred you to us?: ____

Referring Physician: ____

Family Doctor (PCP): ____

Specialist (OB-GYN, Pain Doctor, Etc): ____

Case Profile and History

Have you been treated by a Physical/Occupational Therapist this year? ☐ Yes Number of Visits ________ ☐ No

Physical/Occupational Therapist name: ______________________________Phone: ______________________

Are you **currently** being treated by a Chiropractor? ☐ Yes ☐ No Date of Last Visit: ____________

Do you have (or had) any medical conditions that we should be aware of? ___________________________

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Making Appointments: all physical therapy treatments are by appointment only. If you need to cancel a scheduled appointment call us 24 hours in advance. **If appointments are broken less than 24 hours in advance you will be charged a fee of $75 for the first cancellation and $150 for subsequent cancellations**.

- **Please be on time for your appointments**: if you are late we reserve the right to either, shorten your treatment time or, cancel your appointment and charge you the $75 or $150 cancellation fee.
- **We strongly recommend that you schedule as many appointments in advance as possible**. Mornings. lunchtimes and evenings are very popular appointment times and are booked on a first come, first served basis.

Patient Responsibility

Taking of the history and conducting a physical examination are an integral part of your treatment and are part of the process of information gathering to determine future care. I understand and agree that heath and accident policies are an agreement between an insurance carrier and myself. Furthermore, I understand that MRPT Physical Therapy, LLC will prepare any necessary reports and forms to assist me in making collection from my insurance company. **I understand that verification of insurance benefits are not a guarantee of payment and that my insurance company may deny claims if not deemed "medically necessary".** I authorize my insurance company to assign any insurance benefits for my Physical/Occupational Therapy treatments directly to MRPT Physical Therapy, LLC.
I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment including any co-payment or co-insurance. If I suspend or terminate my care and treatment, all patient balance, after insurance payment will be due immediately. If I choose to ignore my responsibility I agree to be liable for all collection and attorney fees if deemed necessary.

Signature: _________________________________ **Date:** _____________________________

Please Turn over

MRPT Physical Therapy, LLC

HIPPA COMPLIANCE
AUTHORIZATION FOR DISCLOSURE AND USE OF MEDICAL RECORDS

- **I HEREBY AUTHORIZE** my Primary Care Physician or other specialist to release to **MRPT Physical Therapy, LLC** medical information such as

LAB REPORTS, X-RAY REPORTS, MRI REPORTS and all related medical information as appropriate to assist with the diagnosis and your physical therapy treatment at
MRPT Physical Therapy, LLC.
We may need to communicate with your Primary Care Physician or other specialist concerning your treatment. Should you not wish us to communicate with your Primary Care Physician or other specialist please advise us in writing.

- **I HEREBY AUTHORIZE** **MRPT Physical Therapy, LLC** to disclose my medical records to my insurance company for the purpose of assisting with the settlement of my insurance claims for Physical Therapy.

I UNDERSTAND THAT THIS AUTHORIZATION SHALL BE VALID UNTIL I REVOKE THE AGREEMENT THROUGH WRITTEN NOTICE TO MRPT PHYSICAL THERAPY, LLC

Name: .... **Signature:**..................................

Date:..

HIPAA Privacy Statement

Our practice is committed to maintaining the privacy of your protected health information (PHI), while providing high quality medical care. In accordance with the HIPAA regulations this notice explains:

- How we may use and disclose your PHI.
- Your privacy rights regarding your PHI.
- Our obligations concerning the use and disclosure of your PHI.

We may use and disclose your PHI for treatment, payment, and health care operations (TPO).
You have the right to inspect, copy, and amend your PHI. You have the right to request restrictions on the use of your PHI. You have the right to an accounting of the disclosures of our PHI for other than TPO.

You have the right to complain about alleged violation to this practice's privacy officer and the U.S. Department of Health and Human Services.

If you have questions, please feel free to meet with our privacy officer for clarification or assistance.