PATIENT INFORMATION

Today's Date:_____

Patient Name:_____ SSN#_____
Address:_____ City/State/Zip _____
Home#:_____ Work:_____ Cell:_____
Age: _____ Date of Birth:_____ Sex: Male ____ Female _____
In case of Emergency Name:_____ Number:_____
Marital Status: Single ___ Married ___ Divorced___ Separated ___ Widowed ___

Student Status: FT PT or Non-student. School Attending:_____

Are you employed? Yes No Occupation:_____
Employer_____
Address _____City/State/Zip _____

Date of current illness? _____Cause of Condition: Illness ___ Job Related ___ Auto Accident ___
WComp ___ Other____

Referring Physician_____
How did you hear about us?_____
Email Address: _____
(Your email will not be given out and will only be used for our office to keep you updated on company and community events.)

INSURANCE INFORMATION

Primary Insurance Company _____ ID#_____
Relationship to the insured _____Group # _____
Primary Insured Name: _____ Insured DOB:_____
Policy/Claim # _____ Phone #_____
Date of Injury _____ Adjustor's Name_____
Billing Address _____

SECONDARY INSURANCE (OR HEALTH INSURANCE IF WCOMP/AUTO)

Name: _____ Phone # _____
Policy/Claim # _____ Group #_____
Billing Address _____

ALL PATIENTS AND RESPONSIBLE PARTIES PLEASE READ AND SIGN

I authorize release of any medical information necessary to process the claim. I authorize the payment of medical benefits directly to this office for services rendered. I understand that I am financially responsible for charges not covered by this authorization, except where prohibited by law. If the delinquent account is referred for collection and/or litigation, patient agrees to pay Atlas's collection agency fees, attorney's fees and court costs associated with the collection/litigation process.

Signature _____ Date _____

ATLAS
PHYSICAL THERAPY & SPORTS MEDICINE, INC.

CONFIDENTIAL PATIENT HEALTH HISTORY FORM

Name _____ Today's Date _____

DOB _____ Height _____ Weight _____

Please place an "X" in the space provided if you have had any of the following conditions:

___ Heart Disease
___ Diabetes
___ Prolapsed Mitral Valve
___ Glaucoma
___ Tuberculosis
___ AIDS
___ Liver Disease
___ Leukemia
___ Ulcers
___ Mental/Psychiatric Disorder
___ Stroke
___ Heart Murmur
___ Colitis
___ Epilepsy
___ Artificial Prosthesis
___ Hearing Loss
___ Pregnant
___ High Blood Pressure
___ Lung Disease
___ Rheumatic Fever
___ Arthritis
___ HIV
___ Kidney Disease
___ Thyroid Disease
___ Hepatitis
___ Pacemaker
___ Metal Implant
___ Swollen Ankles
___ Sinusitis
___ Asthma
___ Cancer

___ Other _____

Please list any surgeries you have had related to your current physical therapy problem:

_____

Please list any previous surgeries:

_____

Who is your family Physician? _____

When was your last physical exam? _____

DO YOU HAVE ANY ALLERGIES? _____

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MEDICATION LIST

Please list any and all prescription, over the counter, herbal and supplemental medications you are currently taking. Please include the following information pertaining to each item: name, dosage, frequency and route of administration (i.e. oral, spray, etc.). If you carry a personalized meds list, we can make a copy of that for your records but please ensure it has ALL of the information below on it.

NAME	DOSAGE	FREQUENCY	ROUTE

CONDITIONS OF ADMISSION

_____The patient is under the control of their physician, and undersigned consents to any treatment of procedures rendered to the patient by Atlas Physical Therapy under the general and specific instructions of the physician. It is further understood that Atlas Physical Therapy is authorized to carry out all instructions of the patient's physician and that Atlas Physical therapy is herby relieved of any and all liability occurring from the performance of the physician's instruction. I request and authorize the staff of Atlas Physical Therapy to provide me with treatment, and to perform any procedures now contemplated or such additional procedures as my physician may deem reasonable and necessary.

_____I acknowledge that I have received/declined a copy of the Notice of Our Privacy Practices from the office of Atlas Physical Therapy & Sports Medicine, Inc. I understand that some of my health information may be used and/or disclosed by Atlas Physical Therapy to carry out treatment, payment, or health care operations, and that for a amore complete description of such uses and disclosures, I should refer to your privacy notice entitled, "Notice of Our Privacy Practices." I understand that I may review this privacy notice at any time prior to or after signing this form. I understand that over time the privacy practices may need to change in accordance with the law and that if I wish to obtain a copy of this notice as revised, I can call your office to request such copy.

_____I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care operations and that I can also revoke this consent in writing, but only to the extent that your practice has not taken action in reliance thereon.

_____I understand that for my protection any requests to amend my health information or to access my medical records must be made in writing.

_____I understand that if I need to cancel an appointment I will do my best to call within 24 hours. It is understood that 24 hours will not always be possible, however if there are consistent cancellations or failures to show for scheduled appointments, there will be a $50.00 fee that will be assessed to your account. We also reserve the right to discharge you from care and notify your physician for non-compliance.

_____ It is understood that insurance coverage is an agreement between you and your insurance company. As a courtesy, we will verify your benefits prior to your arrival, file medical claim forms with primary and secondary insurances, and assist you in seeing that services rendered are paid for according to your insurance plan. Any remaining balance after these steps have been taken is your responsibility.

_____Co-pays will be paid in full prior to services being rendered. It is expected that payments will also be made towards balances accrued for deductibles and co-insurances. We will keep you informed of your balance at each visit, as well as, mail monthly statements to your address.

Patient Signature _____ Date _____

Witness (Person securing Request)_____ Date_____

Medical Information Release Form (HIPAA Release Form)

Name: _____D.O.B. _____/_____/_____

Release of Information

_____ I authorize the release of information including the diagnosis, records; examination rendered to me as well as claims and financial information. This information may be released to under my consent:

____ Spouse _____

____ Child (ren) _____

____ Other _____

_____ I decline authorization to release my information to anyone other than myself.

This **release of information** will remain in effect until terminated by me in writing.

Phone Messages

Please call ( ) my home ( ) my work ( ) my cell

If unable to reach me:

( ) you may leave a detailed voice message

( ) please leave a message simply asking me to return your call

( ) _____

The best time to reach me is (day) _____ between (time) _____

Signature: _____ Date: ____/____/_____

Witness: _____ Date: ____/____/_____

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MEDICARE CONDITIONS OF ADMISSION

Medicare has implemented the "Therapy Cap." This cap states that Medicare will only allow $1980 a year for 2017 for outpatient Physical and Speech language pathology services combined. For this office that is approximately 15 visits per year. There are exemptions for certain diagnoses and our office can get approval allowing additional visits over the 15. Exemptions do not apply in all cases and are based on the patient's diagnosis provided by the physician.

We will do our best to respect the monetary cap, however we provide service based on patient need not insurance limitations. It is ultimately your responsibility to ensure that services being rendered are covered. If services are not covered or exceed the monetary therapy cap, then financial responsibility lies with the patient.

I authorize the payment of medical benefits directly to this office for services rendered. I understand that I am financially responsible for charges not covered by this authorization, except where prohibited by law.

Printed Name_____ Date _____

Patient's Signature_____

FINANCIAL POLICY FOR MINORS

Minor patients (under the age of 18) must be accompanied by an adult to their initial visit. After the first appointment it is parental discretion whether or not the child has adult supervision in their following sessions. Please be advised that all copayments are still due at the time of service. You may either phone in your payment or you can choose to send your child in with a form of payment. In relation to coinsurance amounts and deductibles, these totals change on a regular basis so please select a form of communication below so we can assist you in staying informed of your most current balance:

□ please send me an email in relation to my child's balance to this address _____

□ please call me with my child's account balance at this number _____

□ please send my child home with a statement as account changes.

□ My child was injured at school or in a school related activity and has a school claim form that should be filed as a secondary insurance. (Please provide our office with a copy ASAP.)

Parent/Guardian Signature _____ Date: _____