PATIENT NAME: **FIRST**_____ **MI**____ **LAST**_____

DATE OF BIRTH_____ **SSN**_____ **MALE**_____ **FEMALE**_____

STREET ADDRESS_____ **APT#**_____

CITY_____ **STATE**_____ **ZIP CODE**_____

MAILING ADDRESS IFDIFFERENT_____

HOME PHONE_____ **CELL PHONE**_____ **EMAIL**_____

EMPLOYER_____ **PHONE**_____

ADDRESS_____ **CITY**_____ **STATE**_____ **ZIP**_____

SPOUSE'S NAME_____ **CELL PHONE**_____ **WORK PHONE**_____

EMPLOYER_____ **PHONE**_____

ADDRESS_____ **CITY**_____ **STATE**_____ **ZIP**_____

EMERGENCY CONTACT_____ **RELATIONSHIP**_____ **PHONE**_____

REFERRING PHYSICIAN_____ **PHONE**_____

LAST DATE SEEN_____ **NEXT PHYSICIAN VISIT**_____

FAMILY PHYSICIAN_____ **PHONE**_____

ACCIDENT RELATED INJURY? YES___ **NO**___ **DATE OF ACCIDENT**_____

HOW DID YOU HEAR ABOUT US? □REFERRING PHYSICIAN □FAMILY □FRIEND □ATHLETIC TRAINER □OTHER_____

PRIMARY INSURANCE:_____ PHONE_____
INSURED'S NAME:_____ SS#_____ DOB_____
EMPLOYER:_____ PHONE_____
RELATIONSHIP TO THEINSURED _____

SECONDARY INSURANCE:_____ PHONE_____
****A $10.00 FEE WILL APPLY TO FILE YOUR SECONDARY (DOES NOT APPLY TO MEDICARE)*
INSURED'S NAME:_____ SS#_____ DOB_____
EMPLOYER:_____ PHONE_____
RELATIONSHIP TO THEINSURED_____

Patient Signature or Guardian if a minor **Date**

MEDICAL HISTORY

Please answer the following questions as applicable and sign the bottom of this form.

Heart Disease
□ Heart Attack
□Arteriosclerosis
□Rheumatic heart disease
□Heart murmur
□CHF
□Pacemaker/Defibrillator

Lungs
□Asthma
□Emphysema
□Turberculosis
□Shortness of Breath

Muscle Conditions
□Carpal Tunnel
□Tennis Elbow
□Back Problems
□Neck Problems

Blood Pressure
□Normal
□High
□Low

Other Conditions
□MultipleSclerosis
□Epilepsy/seizures
□Gout
□Lupus
□Sprains/Fractures
□Osteoporosis
□Cancer
□Hepatitis
□Diabetes
□Rheumatoid Arthritis
□Polio
□Night sweats/unexplained fevers
□Fainting
□Hearing loss
□Depression

□**Other conditions not listed above**: _____

- **Female Patients:** Are you pregnant? □Yes □No
- **Tobacco User:** □Yes □No
- **List known allergies:** _____
- **List any prior injuries:** _____ ❑**None**
- **List any current injuries:** _____ ❑**None**
- **List any prior surgeries**: _____

  _____ ❑**None**
- **List any current surgeries**: _____ ❑**None**
- **Please list any medications, including over the counter, you are currently taking (include pills, injections, and/or skin patches)** _____

  _____
- **Have you had physical therapy, speech therapy or chiropractic treatment in the current year? If yes, please explain:** _____
- **Are you currently receiving Home Health services (nursing, therapy, other)?** □Yes □No
- **Have you fallen or more times in the past year?** □Yes Date(s) of Fall(s)_____□No

_____

Patient Signature of Guardian if a minor **Date**

HIPAA OMNIBUS RULE

CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT RECORDS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____

Please ***print*** your name Please ***sign*** your name

_____ _____

Legal Representative Description of Authority

Your comments regarding Acknowledgements or Consents:

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Sir Name ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation ☐ Email: _____

☐ Home Phone Confirmation ☐ Work Phone Confirmation ☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation ☐ Email: _____

☐ Home Phone Confirmation ☐ Work Phone Confirmation ☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message ☐ Text Message ☐ Email ☐ **None of the above**

_____

Patient Signature or Guardian if a minor Date

FINANCIAL POLICY

PAYMENT IS DUE WHEN SERVICES ARE RENDERED. Please read our financial policy carefully. If you have any questions about this policy, our staff will be glad to assist you.

PAYMENT PROCEDURE: (Please check the manner in which you will be paying)

( ) GROUP HEALTH INSURANCE:
We will file your claims to your insurance company and verify your benefits. We will inform you of any deductible, coinsurance or copayment amounts as quoted by your insurance. We require that you pay any deductible, copayment or coinsurance at the time of treatment. Benefits are subject to final approval by your insurance company; therefore, the amount is subject to change. **We file primary insurance as a courtesy; however if you have secondary coverage and would like our office to file there will be a $10.00 fee (this does not apply to Medicare secondary coverage). INITIAL____**

( ) SELF PAY: Payment is due when services are rendered. **INITIAL_____**

( ) **AUTO ACCIDENT/PERSONAL INJURY:**
This office **DOES NOT** accept liability insurance as a form of payment. We do not get involved in the legal procedures; therefore payment is due at the time services are rendered. We are, however, eager to assist all patients in need of care. We will be glad to verify auto accident/personal injury benefits with your personal health insurance**. INITIAL_____**

( ) **WORKERS COMPENSATION:**
We will accept worker's compensation if your insurance carrier or employer notifies our office prior to your visit with verification and authorization for services. **WE WILL NEED A COPY OF YOUR GROUP INSURANCE CARD** to keep in your file should your worker's comp claims be denied, at which time, you would be responsible for the bill. **INITIAL____**

**** Any balance that remains unpaid 20 days after services are rendered is the responsibility of the patient/guardian and will be subject to a finance charge. *** Delinquent accounts will be forwarded to a collection agency if payment is not received.* ***INITIAL_____***

**** There will be a $25 fee for appointments cancelled or broken without 24 hour advanced notice.** INITIAL____**

Your signature is consent for Dosher Physical Therapy Associates to use automated or predictive dialers to contact you on all numbers provided, including cell phones, concerning any unpaid or remaining balance on your account. This will also include any outside collection agency if your account is assigned to collections for delinquent or past due accounts. **I understand that I am financially responsible for services not covered or deemed not medically necessary by my insurance company. I further understand that Dosher Physical Therapy Associates may not be aware of non-covered services at the time of treatment. I have read and understand my obligation.**

_____ _____

Patient Signature or Guardian if a minor **Date**

CONSENT FOR TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION

I HEREBY AUTHORIZE **DOSHER PHYSICAL THERAPY ASSOCIATES** TO ADMINISTER TREATMENT AS NECESSARY. I ALSO UNDERSTAND THAT NO GUARANTEE HAS BEEN MADE AS TO THE RESULTS THAT MAY BE OBTAINED.
I authorize the release of information in the course of treatment including, but not limited to medical records, oral communications to my insurance company, employer (if applicable) physician and/or third party. **INITIAL____**

BENEFIT ASSIGNMENT: I hereby authorize payment be made directly to Dosher Physical Therapy Associates. If my insurance company should require that payment be made to me, I will in turn issue payment to Dosher Physical Therapy Associates for any charges that I have not previously paid and/or charges that are not covered by my insurance company. **INITIAL____**

PATIENT ACKNOWLEDGEMENT OF RECEIPT OR REQUEST OF NOTICE OF PRIVACY PRACTICES

A copy of Dosher Physical Therapy Associates (herein after "DPTA") Notice of Information Practices is available upon request. I understand DPTA may use or disclose my personal health information (herein after "PHI") for purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand I have the right to restrict how my PHI is used and disclosed if I notify the practice. I also understand that DPTA will consider requests for restriction on a case by case basis, but does not have to agree to requests or restrictions.
I hereby consent to the use and disclosure of my PHI for purposes as noted in DPTA Notice of Information Practices. I understand I retain the right to revoke this consent by notifying the practice in writing at any time. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

_____ _____

Patient Signature or Guardian if a minor **Date**

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because: It was emergency treatment _____
I could not communicate with the patient _____
The patient refused to sign _____
The patient was unable to sign because _____Other (please describe)
_____ Signature of Privacy Officer

GOOD FAITH ESTIMATE

You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost.

Under the law, health care providers need to give patients who don't have insurance or who are not using insurance an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call 800-985-3059.