Patient Information

*We cannot process your insurance claim without the required fields filled out

Patient's name*: _____ Today's date*: _____

Street address*: _____ SSN*: _____

City and State*: _____ ☐ Male ☐ Female

Zip Code*: _____ Home phone*: _____ Date of Birth*: ____/____/____

Work phone: _____ Cell: _____

Email: _____

Family Physician: _____

Person to contact in case of emergency: _____

Phone: (_____) _____ Relationship: _____

Accident/Injury Information

Date of Accident or Injury related to this current episode: _____/_____/_____

How did accident or injury occur: _____

Accident type: ☐ Work ☐ Auto ☐ Fall ☐ None ☐ Other

Is there pending litigation concerning your injury? _____

If yes, attorney name: _____ Phone: _____

Attorney address: _____

Insurance Information

PRIMARY INSURANCE COMPANY NAME: _____

Policy number: _____ Group number _____

Relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

SECONDARY INSURANCE COMPANY NAME (if applicable): _____

Policy number: _____ Group number: _____

Relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

How did you find out about us?

☐ Friend ☐ Physician ☐ Family Member ☐ Website ☐ Phone Book ☐ Internet

☐ Facebook ☐ Other _____

Patient/Guardian Signature:_____ **Date:**_____

Consent for Care and Treatment, Benefit Assignment/Release of Information, Information Privacy

I, _____, do hereby agree and give my consent for Resolve PT and Rehabilitation, LLC to furnish medical care and treatment to me that is considered necessary and proper in diagnosing or treating my condition. I hereby assign all medical to include major medical benefits to which I am entitled, including Medicare, Medicaid, and third party payers to Resolve PT and Rehabilitation, LLC. I hereby authorize said assignee to release all information necessary, including medical records to secure for the care we provide, and for other health care operations, including those activities we perform to improve our quality of care. A summary of our Notice of Privacy Practices is furnished to you at the time of admit, however a complete version of our Privacy Practices is available upon request.

I certify that the information furnished by me is correct and hereby direct and authorize payment of health care benefits due me by insurer to Resolve PT and Rehabilitation, LLC. I understand that I am financially responsible for payment of fees regardless of insurance coverage. I also certify that I have received the initial patient information from Resolve PT and Rehabilitation, LLC.

I understand that payment of all medical treatment rendered by Resolve PT and Rehabilitation, LLC is my responsibility. Resolve PT and Rehabilitation, LLC will make every attempt to receive reimbursement from my insurance company (s) of all services rendered. However, in the event that coverage is denied for any reason then full payment is my responsibility. Patients will have up to thirty days to pay their balance in full. After 30 days a 1.5% interest fee per month will accrue, and full payment is required by no later than 90 days. Failure to submit payment within 90 days will be result in patient balance being charged to their credit or debit card on file. If we do not have one on file then the balance will be forwarded to a predetermined collection agency, with a $75 collection administrative fee added to your current patient balance. I give Resolve PT and Rehabilitation, LLC permission to share all required medical information with the collection agency of their choice for the sole purpose of receiving payment for their services.

I have read and understand Resolve PT and Rehabilitation, LLC.'s HIPPA privacy notice. I further understand that I may obtain a copy of this privacy notice upon my request. I have read and understood Resolve PT and Rehabilitation, LLC.'s billing and collection policies, initial disclosure, and cancellation and no show policies. I further understand that I may obtain a copy of this policy upon my request.

Print Name: _____

Patient Signature: _____ **Date:** _____

Responsible Party's Signature (if patient is a minor): _____

Name:_____ **Date:**_____

Medical History

Are you on a work restriction from your Doctor? ☐ Y ☐ N Ht:_____ '_____" Wt:_____ #

Do you have a pacemaker? ☐ Y ☐ N

FOR WOMEN: Are you currently pregnant or think you might be pregnant? ☐ Y ☐ N

ALLERGIES: Please list any medical allergies:_____

Have you RECENTLY noted any of the following *(Check all that apply)*?

☐ fatigue	☐ numbness or tingling	☐ constipation
☐ fever/chills/sweats	☐ muscle weakness	☐ diarrhea
☐ weight loss/gain	☐ Dizziness/lightheadedness	☐ shortness of breath
☐ nausea/vomiting	☐ Heartburn/indigestion	☐ fainting
☐ difficulty maintaining balance while walking	☐ difficulty swallowing	☐ cough
☐ changes in bowel/bladder function	☐ falls	☐ headaches

Have you EVER been diagnosed with any of the following conditions *(Check all that apply)*?

☐ cancer:	☐ depression	☐ thyroid problems
☐ heart problems:	☐ eye problems/infection	☐ anemia
☐ lung problems:	☐ asthma	☐ tuberculosis
☐ high blood pressure	☐ osteoporosis	☐ multiple sclerosis
☐ circulation problems	☐ osteoarthritis	☐ epilepsy
☐ chest pain/angina	☐ other arthritic condition	☐ blood clots
☐ stroke/TIA	☐ bladder/UTI	☐ ulcers
☐ diabetes	☐ kidney problems/infection	☐ liver problems
☐ Bone/joint infection:	☐ STD/HIV	☐ hepatitis
☐ chemical dependency(e.g. alcoholism)	☐ pelvic inflammatory disease	☐ pneumonia

Has anyone in your immediate family (parents, siblings, grandparents) EVER been diagnoses with any of the following conditions *(Check all that apply)*?

☐ cancer:	☐ tuberculosis	☐ diabetes
☐ heart problems:	☐ thyroid problems	☐ stroke
☐ high blood pressure	☐ depression	☐ blood clots

Do you smoke? ☐ Yes ☐ No Packs per day_____

Have you ever received physical therapy? ☐ Yes ☐ No For what purpose_____

Medications:_____

_____

Briefly describe your reason for coming to physical therapy today:_____

_____

What goals do you wish to achieve?_____

_____

Patient Signature:_____ **Date:**_____

Therapist Signature:_____ **Date:**_____

Cancellation Policy/No Show Policy For Doctor Appointments and Surgery

1. Cancellation/ No Show Policy for Doctor Appointment

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance you will be charged a fifty-two dollar ($52) fee; this will not be covered by your private insurance company or worker's compensation provider.

2. Scheduled Appointments

We understand that delays can happen however we must try to keep the other patients and doctors on time. If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.

3. Account balances

We will require that patients with self pay balances do pay their account balances to zero (0) prior to receiving further services by our practice. Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns. Patients with balances over $100 must make payment arrangements prior to future appointments being made.

Print Name :_____

Signature Patient/Guardian:_____ **Date:**_____

Patient Consent for Use and Disclosure of Protected Health Information:

I hereby give my consent for **Resolve PT and Rehabilitation, LLC** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by **Resolve PT and Rehabilitation** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Resolve PT and Rehabilitation, LLC.** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Resolve Physical Therapy and Rehabilitation, Attn: HR Dept., 112 Walmart Supercenter, Siler City, NC 27344.**

With this consent, **Resolve PT and Rehabilitation, LLC.** may call or text my cell phone, call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, invoices, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **Resolve PT and Rehabilitation, LLC.** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, **Resolve PT and Rehabilitation, LLC.** may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **Resolve PT and Rehabilitation, LLC.** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

With this consent, **Resolve PT and Rehabilitation, LLC** may attempt to receive payment of their services by use of a collection agency. I understand that payment of all medical treatment rendered by Resolve PT and Rehabilitation, LLC is my responsibility. Resolve PT and Rehabilitation, LLC will make every attempt to receive reimbursement from my insurance company (s) of all services rendered. However, in the event that coverage is denied for any reason then full payment is patient responsibility. Failure to comply with these terms could result in use of a collection agency, and I give Resolve PT and Rehabilitation permission to share my medical information with the collection agency of their choice for the sole purpose of receiving payment for their services with an additional $75 processing fee added onto your balance.

By signing this form, I am consenting to allow **Resolve PT and Rehabilitation, LLC.** to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Resolve PT and Rehabilitation, LLC.** may decline to provide treatment to me.

Signature of Patient or Legal Guardian: _____ Date:_____

Print Name of Patient or Legal Guardian:_____ Date:_____