HealthPRO
PHYSICAL THERAPY

Date ____/____/____ Referred By _____

Name (First, M, Last) _____ SS#____/____/____

Single or Married Address _____

City _____ State _____ Zip_____

Home # _____ Cell #_____ Date of Birth ____/____/____

Email Address _____

Employer _____ Work # _____

Employer Address _____ City _____ State_____ Zip_____

In an Emergency, who should we notify? _____ Phone # _____

RESPONSIBLE PARTY INFORMATION

Type of Insurance: (please check one) ☐ Self ☐ Medical ☐ Auto ☐ Workers Comp ☐ Attorney

Name _____ Phone #_____

Address _____

City _____ State _____ Zip _____

Policy # _____ Group # _____

Claim # _____ Adjuster Name _____

SECONDARY INSURANCE : ☐ Yes ☐ No

ASSIGNMENT AND RELEASE

** Policy holder's DOB ____/____/____ SS # ____/____/____

Sex: Male or Female Relationship to Patient _____

I, the undersigned, has insurance coverage with _____ and assign directly to **HealthPro Physical Therapy** all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all chargers whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____

Responsible Party Signature Date

Health Questionnaire

Patient name: _____ Date: _____

What are your main problems/pains? _____

Have you seen another Physician for this problem? (Y) (N) Whom? _____

Date of Accident/Beginning of Illness _____ Location of Accident _____

☐ Auto ☐ On the Job ☐ Other Describe circumstances of accident/injury_____

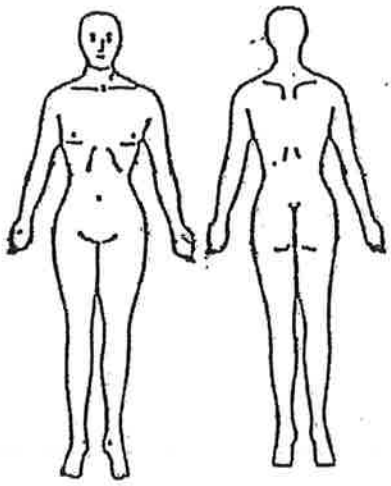
_____

_____

Have you lost time from work? _____ Are you Pregnant? _____

Please check the following symptoms that you have experienced or currently experiencing

MUSCULO-SKELETAL SYSTEM
- ☐ Low Back Problems
- ☐ Pain between Shoulders
- ☐ Neck Problems
- ☐ Arm Problems
- ☐ Leg Problems
- ☐ Swollen Joints
- ☐ Painful Joints
- ☐ Stiff Joints
- ☐ Sore Muscles
- ☐ Weak Muscles
- ☐ Walking Problems
- ☐ Ruptures
- ☐ Broken Bones
- ☐ Numbness



-PLEASE COLOR IN AREAS OF PAIN-

GENITO-URINARY SYSTEM
- ☐ Bladder Trouble
- ☐ Excessive Urination
- ☐ Scanty Urination
- ☐ Painful Urination
- ☐ Discolored Urination

EAR, NOSE AND THROAT
- ☐ Eye Strain
- ☐ Eye Inflammation
- ☐ Vision Problems
- ☐ Ear Pain
- ☐ Ear Noises
- ☐ Nose Bleeding
- ☐ Nose Discharge

CARDO-VASCULAR/RESPIRATORY
- ☐ Chest Pain
- ☐ Difficulty Breathing
- ☐ Persistent Cough
- ☐ Coughing Blood
- ☐ Rapid Heart Beat
- ☐ Blood Pressure Problems
- ☐ Heart Problems
- ☐ Lung Problems
- ☐ Varicose Veins

NERVOUS SYSTEM
- ☐ Liver Trouble
- ☐ Paralysis
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Muscle Jerking
- ☐ Convulsions
- ☐ Depression

Allergies: _____

Medications Presently Taking: _____

Prior Surgeries: _____

HEALTHPRO PHYSICAL THERAPY POLICIES

OUR PRACTICE POLICY

We are dedicated to providing you with the best possible care and service, and we want to help you understand our financial policies as an essential part of your care and treatment. To assist you, we have the following payment policy. If you have any questions, please feel free to discuss them with our staff. For your convenience we accept VISA, MasterCard, checks and cash.

PRIVATE PAYORS

If you do not currently have insurance coverage and you wish to pay for your doctor's visit personally, full payment is required at the time of services. All outstanding balances are due at the time of your next check in. We do not bill for services rendered to "private pay" patients. Any problems with payments should be directed to our office manager.

INSURANCE POLICY

We have made prior arrangements with many insurers and other health plans. We will bill those plans with which we have an arrangement and will collect any required co-payment at the time of service. The co-payments will be collected before you leave our office. If you have insurance coverage with a plan with which we do not have an agreement, we will prepare and send the claim for you, free of charge. In this case, charges for your care and treatment are due at the time of service.

COLLECTION POLICY

I agree that if payment is not made in a timely manner and should this office find it necessary to place my account with an agency for collection. I also agree to pay any and all court costs and attorney fees, on any balance due anc owing.

MINOR PATIENTS

For all services rendered to minor patients, the adult accompanying the patient is responsible for payment at the time of services.

I have read and understand the financial policy of **HealthPro Physical Therapy** and I agree to abide by its terms. I also understand and agree that such policies may be changed from time-to-time by the practice.

Signature of patient or responsible party if a minor

Date

CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I, _____, hereby authorize **HealthPro Physical Therapy** to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, **HealthPro Physical Therapy** can refuse to treat me.

I have been informed that **HealthPro Physical Therapy** has prepared a notice ("Notice") which more fully describe the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations. I understand that I have the right to review such notice prior to signing this consent.

I understand that I may revoke this consent at any time by notifying **Privacy Officer**, in writing, but if I revoke my consent, such revocation will not affect any actions that **HealthPro Physical Therapy** took before receiving my revocation.

I understand that **HealthPro Physical Therapy** has reserved the right to change its privacy practices and that I car obtain such changed notice upon request.

I understand that I have the right to request that **HealthPro Physical Therapy** restricts how my individually Identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that **HealthPro Physical Therapy** does not have to agree to such restrictions, but that once such restrictions are agreed to, my provider must adhere to such restrictions.

_____ _____

Signature of patient or patient's representative | Date

_____ _____

Printed name of patient or patient's representative | Relationship to the patient

I am authorizing H**ealthPro Physical Therapy** to release any/all medical and billing information to the following family members.

Name	**Relationship to the patient**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

HealthPRO
PHYSICAL THERAPY

501 Barrow Street Houma, LA 70360 985-872-577 (P) 985-872-6325 (F)

Date: _____ **Patient Name:** _____

I hereby authorize _____ to release to **HealthPRO Physical Therapy** any and all information pertaining to my accident or illness.

Date of Birth: _____ **Social Security Number:** _____

_____ Complete Health Record
_____ History and Physical Exam
_____ Diagnosis and Treatment Codes
_____ X-ray Films/Images
_____ X-ray Reports
_____ MRI Reports
_____ Discharge Summary
_____ Progress Notes
_____ Surgery Reports
_____ Other

I understand that:
- I may refuse to sign this authorization and that it is strictly voluntary.
- If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
- I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practicies.
- If the requester or receiver is not a health plan or health care provider, the release may no longer be protected by federal regulations and may be redisclosed.
- I understand that I may see and obtain a copy of the information described on this form, for a resonable copy fee, if I ask for it.

Signature: _____ **Date:** _____