TRI-STATE PHYSICAL THERAPY, INC.

DATE________________________________ EMAIL ADDRESS:____

PATIENT'S NAME ____ AGE__________SEX__________ MARITAL STATUS ________

HOME PHONE_____________________________ WORK PHONE______________________________ CELL PHONE________________________

ADDRESS ____APT/LOT#_______ CITY________________ STATE_____ ZIP___________

SSN___________________________________ DATE OF BIRTH____________________ DRIVER'S LICENSE #____________________________

EMPLOYER___________________________ADDRESS____PHONE________________________

NAME OF SPOUSE_________________________________ SSN______________________________ DATE OF BIRTH_____________________

SPOUSE'S PLACE OF EMPLOYMENT_________________________ ADDRESS________________________________PH___________________

INDIVIDUAL RESPONSIBLE FOR BILL_________________________ADDRESS_________________________________ PH __________________

IS PATIENT A MINOR? YES ___ NO___ IF YES, PARENT NAME _______________________ SSN________________PH:__________________

REFERRED BY: ☐ DR. ____________________ ☐ FAMILY/FRIEND ☐ INSURANCE ☐ WEB SEARCH ☐ OTHER__________________________

NAME OF INSURANCE_______________________________ ADDRESS_______________________________________ PH__________________

NAME OF INSURED ______________________________ INSURANCE ID# _______________________________ DOB:_____________________

EMERGENCY CONTACT INFORMATION (NOT LIVING AT YOUR ADDRESS). PLEASE DO NOT LEAVE BLANK.

NAME____ RELATIONSHIP____

PHONE_________________________________ADDRESS____

DATE OF INJURY:__________________________IS YOUR INJURY/SYMPTOMS DUE TO AN ACCIDENT? YES__________ NO __________

IF YES, DID THIS ACCIDENT OCCUR: AT HOME ☐ AT WORK ☐ OTHER ☐ IN AN AUTOMOBILE ☐ IN WHICH STATE__________________

BRIEFLY DESCRIBE THE ACCIDENT____

DO YOU HAVE AN ATTORNEY? (YES NO) IF YES, NAME__________________________________ PHONE__________________________

MEDICAL INFORMATION

DOES YOUR MEDICAL HISTORY INCLUDE ANY OF THE FOLLOWING:

	YES	NO		YES	NO		YES	NO		YES	NO
1. ANEMIA	☐	☐	7. ABNORMAL HEART	☐	☐	13. METAL IMPLANTS	☐	☐	19. CIRCULATION	☐	☐
2. DIABETES	☐	☐	8. ULCERS	☐	☐	14. LUNG DISEASE	☐	☐	20. HEMOPHELIA	☐	☐
3. CORTISONE ALLERGY	☐	☐	9. EPILEPSY/SEIZURES	☐	☐	15. MENTAL ILLNESS	☐	☐	21. BURN INJURIES	☐	☐
4. ANESTHETIC ALLERGY	☐	☐	10. KIDNEY PROBLEMS	☐	☐	16. HIGH BLOOD PRESSUE	☐	☐			
5. PENICILLIN ALLERGY	☐	☐	11. CANCER	☐	☐	17. HEPATITIS	☐	☐			
6. ARTHRITIS	☐	☐	12. PREGNANCY	☐	☐	18. PACE MAKER	☐	☐			

ANY OTHER ILLNESS (PLEASE DESCRIBE): ____

LIST ANY PAST SURGERIES____

BRIEFLY DESCRIBE YOUR SYMPTOMS: ____

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING: ____

ARE YOU ENTITLED TO MEDICARE BENEFITS? (YES NO)

IF YES, ARE YOU CURRENTLY RECEIVING ANY HOME HEALTH SERVICES? (YES___ NO___)

For Office Use Only
Home Health issue discussed with patient if Medicare ?
Initials:

PLEASE ANSWER EACH QUESTION, AND RETURN TO RECEPTIONIST AFTER COMPLETING BACK OF FORM. **PLEASE DO NOT LEAVE ANY BLANKS.**

AUTHORITY TO TREAT

Permission is hereby granted to Tri-State Physical Therapy, Inc., A Professional Medical Corporation, to perform treatments of physical/occupational therapy modalities and procedures as deemed necessary by the licensed physical/occupational therapists.

AUTHORITY TO RELEASE INFORMATION

Permission is hereby granted to Tri-State Physical Therapy, Inc., A Professional Medical Corporation, for the release of my medical records to authorized representatives.

CREDIT POLICY, FEES, PAYMENTS & ASSIGNMENT OF BENEFITS

If you have health insurance, it should be understood that this is an agreement between you and your insurance company. Your therapy bill is an agreement between you and Tri-State Physical Therapy, Inc. Statements will be provided monthly, but any co-pay or co-insurance responsibility is due at the time services are rendered. You are responsible for the payment of your bill regardless of the status of your insurance claim. In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment must not be delayed due to pending insurance claims. If your insurance company does not pay within a reasonable length of time, we will look to you for payment in full.

Most insurance companies do not cover durable goods/supplies, therefore you are responsible for any durable goods/supplies you receive. Payment is required upon purchase, unless prior arrangements are made with our business office.

Charges for medical services at our clinics are billed monthly as a courtesy to our patients. We accept CASH, CHECKS, MONEY ORDERS, VISA, MASTERCARD, AMERICAN EXPRESS and DISCOVER. A minimum payment of $50.00 is required every 30 days. If your account has been set up on a monthly payment plan and payments are not received on time or in the amount specified, a minimum rebilling fee will be assessed. The balance will also be considered delinquent and will be due and payable immediately. If unusual circumstances should make it impossible for you to meet our credit terms, we invite you to call or personally discuss the matter with our credit department. Except when hardship warrants otherwise, accounts 90 days past due will be referred to our collection agency or attorney for further action. If you are involved in a liability claim, representation by an attorney does not constitute payment for services. We will be happy to provide your attorney and/or insurance carrier with an itemized statement for your reimbursement. Due to the length of time these cases take for settlement, it is both unrealistic and very costly for us to wait for payment upon settlement.

I will be responsible for payment of the total bill incurred as a result of treatment received. Although I may choose to use insurance coverage to pay all or any portion of the bill incurred, I understand that the filing of insurance forms does not constitute payment of any portion of the bill and I understand that I am responsible for all charges billed to me for treatment of the above patient. I accept full responsibility for payment of the total balance of my account. **I understand I will be responsible for all collection costs, attorney fees and court costs if my account becomes delinquent.**

I have this date assigned to Tri-State Physical Therapy, A Professional Medical Corporation, the benefits due under my existing policy or policies of insurance. I understand in so far as they are necessary to cover such expenses, that the above assignment of insurance is accepted by Tri-State Physical Therapy, A Professional Medical Corporation, as a convenience to me and said corporation is hereby given my consent to file claims on said policy and to do such other actions as it deems necessary in connection therewith so as to promptly obtain payment under the said policy. I direct my insurance company to pay Tri-State Physical Therapy, A Professional Medical Corporation, directly, without payment to me. I authorize my attorney to pay Tri-State Physical Therapy, Inc. directly from any settlement proceeds

---

MEDICARE POLICY

I certify that the information given by me in applying for payment under Title IVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf to Tri-State Physical Therapy, Inc. I agree to pay all deductibles and co-insurance amounts not reimbursed by my insurance policies.

I, the undersigned, have read and understood the above Authority to Treat, Authority to Release Information, Credit Policy & Assignment of Benefits and Medicare Policy. I hereby agree to the terms therein.

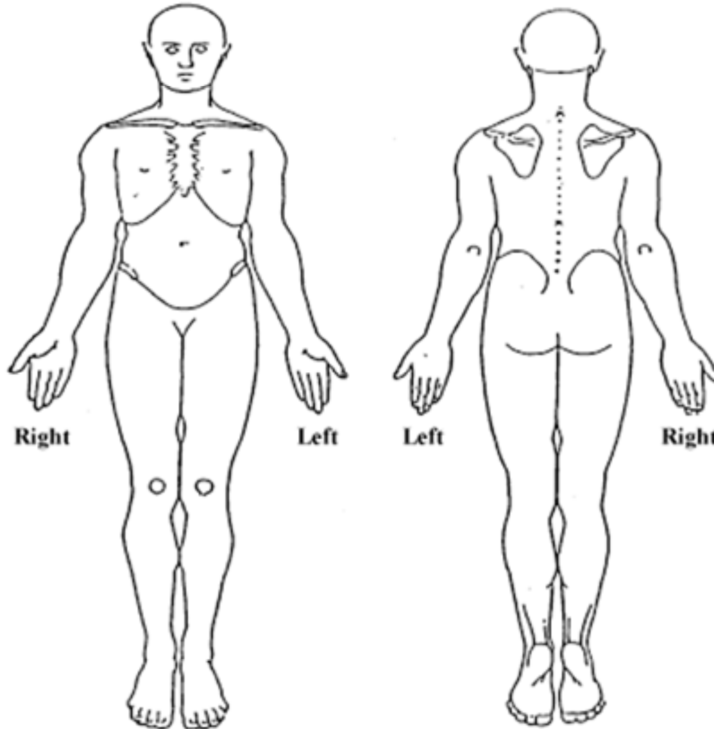
Date: ______________________________ Patient: ______________________________

Witness: ______________________________ Responsible Party: ______________________________

Pain and Symptom Status Report

Name: ______________________________ **Date:** ______________

Indicate on the body chart below where your pain is located at the present time



______ Aching	______ Throbbing	______ Burning	______ Spasmodic
______ Periodic	______ Dull	______ Sharp	______ Radiating
______ Stabbing	______ Numbness	______ Soreness	______ Tingling
______ Discomfort	______ After Activity	______ Pins and Needles	______

Chief Complaint and Visual Analog Scale

My Chief Complaint is: ______________________________

Date First Symptom of your problem occurred on. ______________

2nd Complaint ______________________________

3rd Complaint: ______________________________

Please circle on the scale below to indicate your <u>CURRENT</u> level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it gets.

Please circle on the scale below to indicate your <u>AVERAGE</u> level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it gets.

Please circle on the scale below to indicate your <u>WORST</u> level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it gets.

Additional Comments ______________________________

8660 FERN AVE, STE 160 * SHREVEPORT, LOUISIANA 71105-5694 * PHONE (318) 631-7999 * FAX (318) 631-9528
2906 PLANTATION DR * BOSSIER CITY, LOUISIANA 71111 * PHONE (318) 746-5295 * FAX (318) 746-5297

DAN B. TURNER, PRESIDENT

Welcome to Tri-State Physical Therapy

We are pleased to have you as patient. We are happy you have chosen us to provide your outpatient therapy. Our team of therapists are committed to offering you a therapy experience that will benefit you, allowing you to better perform your daily activities with less pain and more freedom of movement. We know you have many choices for your treatment so we will work together with you to provide the highest quality of care to assist you with a speedy recovery. Research has shown that physical therapy can help to restore movement, relieve pain, strengthen muscles, improve over-all function and prevent further injury.

Privacy Practices: Please note that our Patient Privacy Practices are posted in the waiting area in our clinics. If you would like a copy, please let the Front Office staff know and they will be happy to supply you with one.

First Visit: Our therapist will evaluate you to determine your specific physical needs in order to establish an individualized treatment program. You and your therapist will discuss and agree upon the goals of your treatment. This initial evaluation will be sent to your referring physician.

Home Program: During the course of your treatment, your therapist will develop an exercise program for you to perform at home. This is an ***important part*** of your rehabilitation and will assist you in obtaining your goals. Be sure to ask your therapist any questions you may have regarding this program.

FOTO Outcomes Measurement Tools: During your treatment time with us you will be asked to periodically complete patient assessments specific to the body part we are treating. We would like to express our thanks for taking your time to complete these short assessments. The data from these surveys are used to assist us in meeting requirements of Medicare and insurance companies. Based on your answers and the FOTO outcomes management scoring, your therapist will be able to set out a custom plan of care that will be more effective, less costly, with less visits. Your real-life therapy performance is measured against the outcomes predicted in this plan. As you take a few more assessments during your course of therapy, each will tell an important part of your story. After your course of care is complete, FOTO assesses your real-life outcomes versus the predictions. This makes it easy for consumers like you to identify clinics that provide quality care in the areas you need it most.

Tardiness: We may have to reschedule your appointment if you are ***more than 10 minutes late.*** We will make every effort to respect your time, and ask that you respect the time of others.

Rescheduling Appointments: We request ***24-hours notice*** if you must reschedule or cancel an appointment. Ideally, rescheduled appointments should be in the same week as the original appointment when possible. Canceling less than 24-hours may result in a fee of ***$25.00.***

No Show: If you fail to come to your scheduled appointment, you may be charged a fee of ***$25.00.***

FINANCIAL POLICY

The following information is provided to avoid any misunderstanding or disagreement concerning payment for services.

Insurance Coverage:

- We have verified your insurance coverage prior to beginning your therapy and will give you an explanation of your coverage ***based on the information given by your insurance company.***
- All claims are submitted to your insurance carriers. Your insurance coverage is an agreement between you and your insurance company. ***It is your responsibility to remit payment for charges not covered by your insurance carrier.***
- Please notify our office team promptly if you have any change in your insurance coverage, employment, address or telephone number.
- We will make every effort to collect payment from your insurance company, including submission of claims and follow-up thereafter. If claims are not processed in a reasonable amount of time, we will contact you. It will then be ***your responsibility*** to contact your insurance company regarding payment.
- If you have any questions regarding your insurance, please speak with our Account Manager who will provide you with further explanation of your insurance benefits.

Co-Pays, Co-Insurance, and/or any unmet deductible amounts are due at the time of service.

- In the event that a check is returned for non-sufficient funds, a $25.00 service fee will be charged to you.
- If there is a balance after all insurances have paid, you will receive a statement which is due and payable within 30 days of the statement date.
- We accept cash, checks and credit/debit cards.

Please give any updated prescriptions as well as correspondence from your insurance company to our office staff.

Our teams looks forward to working with you and your physician to achieve your therapy goals. We appreciate your honest feedback regarding your experience with us and ask that you discuss any questions or concerns with us. Thank you again for choosing Tri-State Physical Therapy.

Acknowledgement of Receipt of Notice of Privacy Practices

Tri-State Physical Therapy reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the Notice of Privacy Practices for Tri-State Physical Therapy.

____

Name of Patient/Patient Representative

____

Signature of Patient

____

Date

____

Relationship of Patient Representative to Patient

(Required if the patient is a minor or an adult who is unable to sign this form)

I give permission to Tri-State Physical Therapy to disclose my protected information to:

____

Relationship to Patient: ___________________________

TRI-STATE PHYSICAL THERAPY   MEDICATION LIST

PATIENT NAME: ____

List all medicines you are currently taking: Prescription and over-the-counter medications, dietary supplements and herbals. Include medications

Prescription Medications Name	Dose (How much)	Frequency (How often)
Over-the-Counter Medications Name of Medication	Dose (How much)	Frequency (How often)

Medication list completed or updated (Date):____________________ Initial: _________ Page _____ of _____