The Therapy Institute

Patient Information

First Name: _____ MI: ___ Last Name: _____

Preferred Name: _____ DOB: _____

Sex: _____ Marital Status: _____ Social Security # _____-_____-_____

Preferred Phone: _____ Alternate Phone: _____

May we leave a message? **[ ]** ***No*** **[ ]** ***Yes*** ***May we leave a message?*** **[ ]** ***No*** **[ ]** ***Yes***

Address: _____

Email: _____@_____

Emergency Contact Name: _____

Emergency Contact Phone: _____ Relationship: _____

Employment: FT PT NA Student Retired Occupation: _____

Name of Employer / School: _____

Did you have surgery for this issue? [ ] No [ ] Yes Date: _____ Date of onset: _____

Have you had / are you having home health care? [ ] No [ ] Yes Date of Discharge: _____

Have you previously had physical therapy for this diagnosis? [ ] No [ ] Yes Details: _____

Workers' Compensation / Motor Vehicle Accident

Did the injury happen at work? [ ] No [ ] Yes

If yes, is there a workers compensation claim? [ ] *No* [ ] *Yes*

Is the injury related to an auto accident? [ ] No [ ] Yes

If yes, in which state did the injury occur? _____

WC or Auto (PIP) Insurance Company: _____

Adjuster / Case Manager Name: _____ Phone: _____

Insurance Coverage *No Insurance / Self Pay* [ ]

Primary Insurance Company: _____

Subscriber Name: _____ DOB: _____ Relationship: _____

Secondary Insurance Company: _____

Subscriber Name: _____ DOB: _____ Relationship: _____

HIPAA Notice & Acknowledgement

I acknowledge that I have received / been offered the Notice of Privacy Practices.

Patient Signature: _____ Date: _____

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Authorization For Use or Disclosure of Information (optional)

My protected health information may be disclosed to the following:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that, as set forth in The Therapy Institute, LLC Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time, by sending written notification to:

The Therapy Institute, LLC
1660 Haslett Rd., Suite 4
Haslett, MI 48840
Attn: Privacy Officer

• • • • •

I understand that:

- A revocation is not effective to the extent that The Therapy Institute, LLC has relied on the use or disclosure of the protected health information.

I understand that I have the right to:

- Inspect or copy my protected health information to be used or disclosed as permitted under the federal law (or state law to the extent that the state law provided greater access rights).
- Refuse to sign this authorization.

With my signature below, I agree to the following:

- **I authorize The Therapy Institute to provide physical therapy prescribed by my physician and/or considered necessary or advisable by my physician, physical therapist, or other healthcare professional.**
- I authorize the release of information requested by my insurance plan for payment.
- I understand that verification of insurance benefits is done as a courtesy and is not a guarantee of payment, coverage, or benefits stated by my insurance carrier.
- I understand that I am financially responsible for any balance not covered by my insurance carrier.

Patient / Personal Representative Signature: _____ Date: _____

Printed Name of Patient / Personal Representative: _____

Authority of Representative: _____

Patient Medical History/Medications Form

Name: _____ Date: _____

Past and Current Medical History/Issues: *(check all that apply)*

- ☐ Cardiac
- ☐ Diabetes
- ☐ Respiratory/Breathing
- ☐ Cancer
- ☐ High Blood Pressure
- ☐ Seizures
- ☐ Circulatory
- ☐ Stroke/TIA
- ☐ Osteoporosis
- ☐ Gastrointestinal
- ☐ Depression/Anxiety
- ☐ Vision
- ☐ Hearing Loss
- ☐ Smoking
- ☐ Blood Clots
- ☐ Gout
- ☐ Headaches/Migraines
- ☐ Autoimmune
- ☐ Arthritis
- ☐ Thyroid
- ☐ Alcohol/drug abuse
- ☐ HIV
- ☐ Kidney
- ☐ Liver/Hepatitis
- ☐ Allergies
- ☐ Anemia
- ☐ Other (explain below)

Additional comments on health history/other health history not listed above that would be relevant to your care:

_____

_____

_____

_____

Please list all relevant surgeries:

_____

_____

_____

_____

Name_____ Date_____

Medication List:

Please list **all** prescription and non-prescription/over the counter medications.

Medication	Frequency

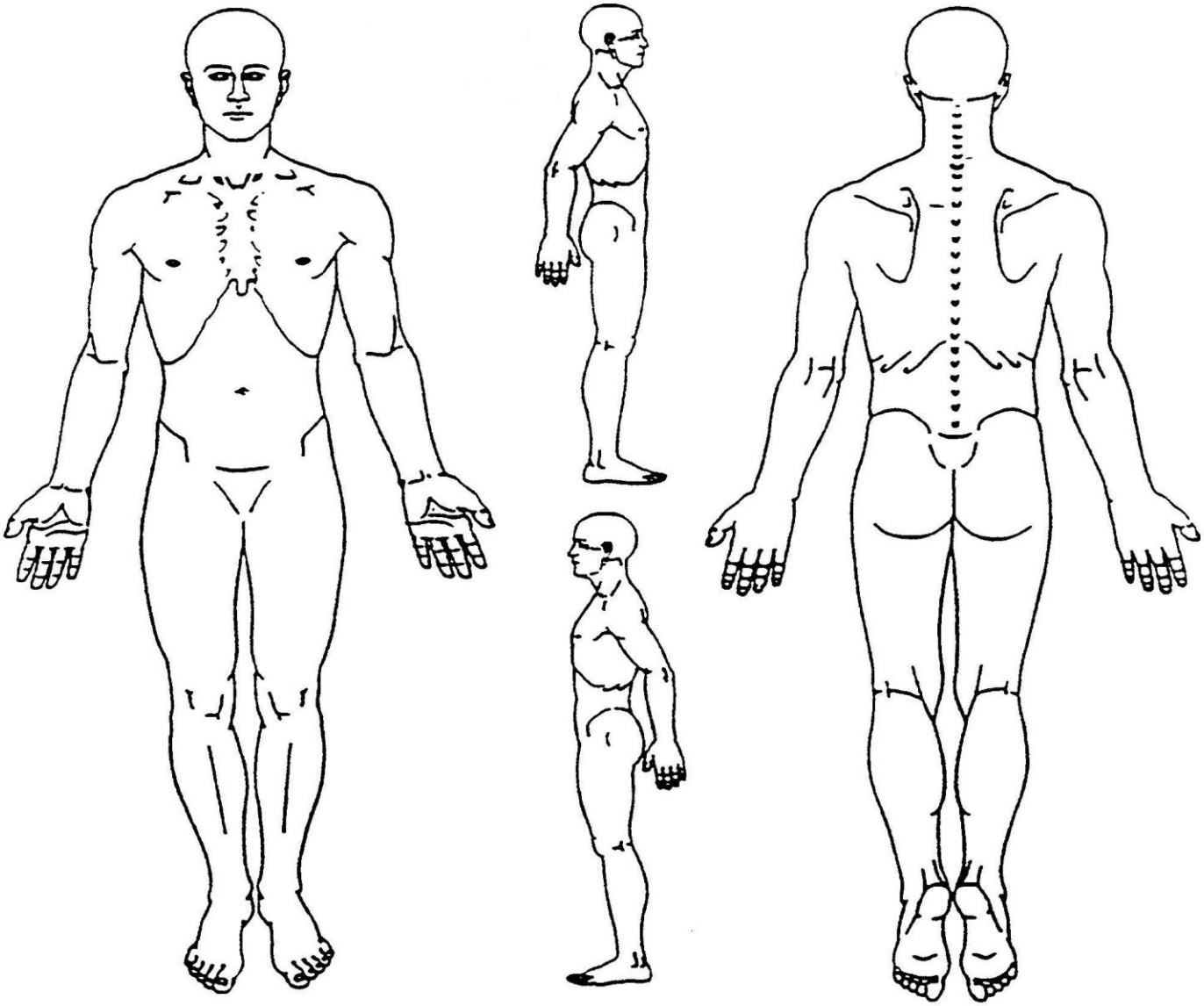
Allergies or reactions (including medications, latex, etc.):

Medication/Agent	Reaction	Medication/Agent	Reaction

Symptom Location

Please indicate on the body chart below where you are experiencing the symptoms that are bringing you into therapy TODAY. *Previous symptoms and episodes may be reviewed by your therapist during your evaluation.*

Patient Name: _____ **Date:** _____



Scheduling Policy

The scheduling policies listed below allow The Therapy Institute to provide prompt scheduling of patients and a wide variety of appointment options. So that we may continue to service our patients in this manner, please note the following scheduling policies are in effect.

1. Patients are expected to attend all scheduled appointments, at the time scheduled.
2. Any cancellation of a scheduled appointment must be made no later than 24 hours prior to the start of the scheduled appointment.
3. Cancellations made without 24 hours notice **may be** subject to a $25 no-show fee payable by you the patient *(not payable by insurance).*
4. If a total of 3 missed appointments are made without cancellation, or if cancellations made with less than 24 hours prior notice are accumulated, you the patient may be required to obtain a new prescription from your physician before you may resume physical therapy.

Billing Information

We at The Therapy Institute strive to make the billing of your medical insurance as easy as possible. As a service to you the patient, we bill your insurance provider. We attempt to determine via your insurance provider whether physical therapy is a covered benefit under your active policy, in addition to what your financial responsibility is if any. This, however, is not a guarantee of payment on their behalf. ***We strongly recommend that you the patient verify your benefits independently.***

To the best of our ability the information gathered is accurate. However, your medical insurance is a contract between you the patient and your insurance provider. The Therapy Institute is not a party to that contract, and you the patient are ultimately responsible for payment in full of any balance due.

Payment of all co-pays or co-insurance charges are expected on a weekly basis. Monies due are payable by cash, check, credit card, or valid HSA card.

*The Therapy Institute bills according to current Medicare guidelines. Any co-pays, co-insurance, or deductible due will be submitted to any active secondary insurance, where applicable, or billed to the patient if there is no secondary insurance.

Patient _____ Date _____

Thank you