Patient Information

PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____ Gender: M F

S.S. Number: _____

Address: _____

_____

Phone # (H) _____ (C) _____

Employer: _____ (W) _____

E-mail: _____

EMERGENCY CONTACT/RESPONSIBLE PARTY

Contact Name: _____

Relationship: _____

Address: _____

_____

Phone: (H) _____

(C) _____

Attorney: _____

_____

How did you hear about us? ☐ Previous Patient ☐ Dr. Referral ☐ Google / Bing / Yahoo ☐ White / Yellow Pages

☐ Family / Friend Person's Name (Optional):

PATIENT HEALTH HISTORY

Referring M.D.: _____

Family M.D.: _____

Injured Area: _____

Date of Injury: _____

How the injury occurred: _____

_____

Height: _____ Weight: _____

List date of last procedure related to injury:

Surgery: _____ Location: _____

MRI: _____ Location: _____

X-ray: _____ Location: _____

Alcohol Use: Never / Occasionally / Frequently

Do you smoke? Yes / No

If "Yes," how many packs per day? _____

Please list any prescribed medications you are taking: _____

_____

_____

Allergies: _____

If you have or have had any of the following ailments, please circle them below:

Pacemaker	Arthritis	Epilepsy	Cortisone Drug
Diabetes Type 1 / Type 2	High Blood Pressure	Anemia	Kidney Disease
Cancer	Bleeding Tendency	Tuberculosis	Stomach Ulcers
Heart Trouble	Nervous Breakdown	Asthma	Rheumatic Fever

Past Medical History (Please list)

Surgeries, Fractures, Other Major Injuries/Illnesses	Year	Hospital/Facility	Treating Physician

Patient Information

Snyder Physical Therapy – New West Orthopaedic & Sports Rehabilitation, LLC

Patient Financial Policy

Please initial next to one of the following payment agreements:

_____ Commercial Insurance Carriers: Policy Holder: _____ Date of Birth: _____
I am covered by one of the listed insurance plans and hereby authorize all payments go directly to Snyder Physical Therapy – New West Orthopaedic & Sports Rehabilitation (SPT–NWR). I agree to pay the amount my insurance plan indicates I am responsible for at the time of service. I agree to provide written authorization prior to my receiving treatment if this is required by my insurance plan.

***Blue Cross Blue Shield**	***Cigna**	***Coventry Healthcare**	***Humana**
***Midlands Choice**	*** Mutual of Omaha**	***TriWest/TriCare**	*** United Healthcare**

_____ Other Insurance: I am covered by an insurance plan that is not listed and hereby authorize all payments to go directly to SPT-NWR. I will pay the portion that my insurance indicates is my responsibility at the time of service.

_____ Medicare: I am a Medicare recipient, and understand that SPT–NWR accepts assignment of Medicare claims. The Medicare Physical Therapy/SLP cap for 2017 is $1980 per year. I understand that SPT–NWR will file my claims for me to both my Medicare and secondary insurance.

_____ Medicaid: I am covered by Medicaid and verify that my coverage is active. If my eligibility status changes I will let SPT–NWR know. I understand that if I am seen without coverage I am responsible for the charges incurred. Should my Medicaid plan have a co-pay or deductible requirement, I agree to make payment at the time of service.

_____ No Insurance: I have no assignable third party coverage and will pay at the time of services rendered. I understand that SPT – NWR will not file an insurance claim for my services.

_____ Law Suit/Liability: Although I am involved in litigation, I am responsible for payment of my account upon the date of services rendered. I understand that SPT-NWR will not wait for payment from any settlement I may or may not receive in the future.
**** Fill out Liability Form**

_____ Workers Compensation: I have a work related injury. SPT-NWR will bill my employer for the services rendered, and in the event of a dispute with my employer about the work-relatedness of my injury, I accept full responsibility for payment of my account. I will provide a copy of my personal health insurance card to SPT-NWR. **** Fill out WC Form**

Please initial all five lines below:

_____ Consent to Treat: I understand that by initialing I am giving permission for evaluation and treatment by SPT-NWR and that I have the right to refuse any procedures after having the risks and benefits explained to me.

_____ Assignment of Benefits: I hereby authorize SPT-NWR to furnish information to the above-named insurance carrier(s) concerning my treatment and hereby assign to the therapist(s) all payments for service rendered. I understand that I am responsible for all charges, even those not paid by my insurance.

_____ **Medical Authorization:** I hereby authorize release of any and all medical records to SPT-NWR. I also consent to the release of my health care records to be reviewed by my insurance company or any necessary audits within SPT-NWR.
I authorize SPT-NWR to release information to: _____

_____ HIPAA Notice of Privacy Practice: I acknowledge that SPT-NWR has offered or supplied me with a copy of their HIPAA Notice of Privacy Practice regarding policies and procedures concerning my Protected Health Information (PHI). I agree to release authorization to SPT-NWR to use my PHI as deemed necessary for treatment, billing and the purposes mentioned in the notice.

_____ **Monthly Statement:** I acknowledge that a Patient Account Statement will be sent at the end of the month from our parent company New West Orthopaedic & Sports Rehabilitation, LLC, located in Kearney, NE. If you have any questions regarding your statement feel free to call the Lincoln office, 402/489-1999 or the Kearney office at 308/237-7388.

Signature: _____ Date: _____
Patient or Legal Guardian (if patient is under 18 years old)