HOMER
PHYSICAL THERAPY

PERSONAL INFORMATION

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: ____ Sex: ☐M ☐F

Preferred Name: _____ Date of Birth (MM/DD/YYYY): _____ Height: _____ Weight: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____ Social Security #: _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed Language: ☐English ☐Other: _____

Custody Status (for minors only) ☐Joint Custody ☐Father ☐Mother ☐Guardian ☐Other:_____

Email: _____ Email Reminders: ☐Yes ☐No

Home Phone: _____ Is it OK to leave a message about your appointment or care? ☐Yes ☐No

Cell Phone: _____ Is it OK to leave a message about your appointment or care? ☐Yes ☐No

Work Phone: _____ Is it OK to leave a message about your appointment or care? ☐Yes ☐No

Occupation: _____Employer: _____

Employer's Address: _____ City: _____ State: ___ Zip Code: _____

Emergency Contact: _____ Phone: _____ Relation: _____

PERSON RESPONSIBLE FOR THE BILL ☐Same as above

Full Name: _____ Cell Phone: _____ Work Phone: _____

Address: _____ City: _____ State: ____ Zip Code: _____

Date of Birth (M/D/Y): _____ Sex: ☐Male ☐Female Relation to Patient: _____

INSURANCE INFORMATION

Primary Insurance: _____

Policy #: _____ Group #: _____

Mailing Address: _____

City: _____

State: _____ Zip: _____

Insurance Phone: _____

Name of Policy Holder: _____

Date of Birth (MM/DD/YYYY): _____

Secondary Insurance: _____

Policy #: _____ Group #: _____

Mailing Address: _____

City: _____

State: _____ Zip: _____

Insurance Phone: _____

Name of Policy Holder: _____

Date of Birth (MM/DD/YYYY): _____

HOMER PHYSICAL THERAPY

PAST MEDICAL HISTORY

Name: _____

Describe current symptoms: _____

Symptoms present since: ___/___/_____ Symptoms are: Improving / Unchanging / Worsening

Commenced due to: _____ / No Apparent Reason

Occupation: _____

Rate your pain: Worst ___/10 Best ___/10 Now ___/10

What makes it better: _____

What makes it worse: _____

Previous treatments for current condition: _____

Imaging (X-Ray / MRI): Yes / No If Yes, Date: ___/___/_____

Surgery performed: Yes / No If Yes, Date: ___/___/_____

Surgery type: _____ / N/A

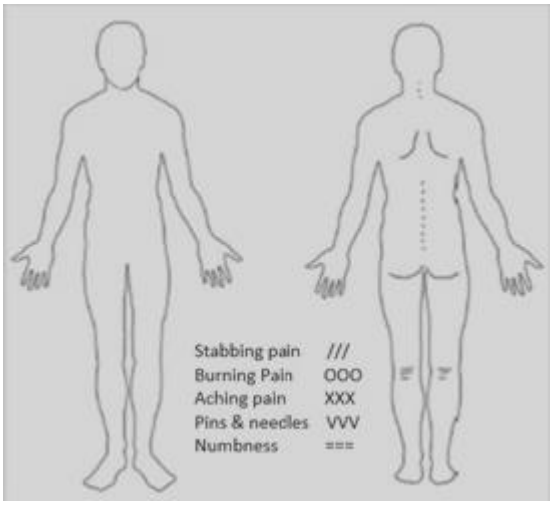
Current functional limitations: None / Minimal / Moderate / Severe

Allergies: _____

Medications: _____

*Please use back of page if needed

Draw your pain on the diagrams shown



Have you recently had:

- ☐ Change in Bowel/Bladder
- ☐ Chills
- ☐ Dizziness
- ☐ Double Vision
- ☐ Difficulty Swallowing
- ☐ Headaches
- ☐ Light Headedness
- ☐ Nausea
- ☐ Night Pain
- ☐ Numbness
- ☐ Shortness of Breath
- ☐ Vertigo
- ☐ Vomiting
- ☐ Weight Loss

Do you have any of the following medical conditions?

- ☐ AIDS / HIV
- ☐ Cancer: _____
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Diabetes: ☐Type I ☐Type II
- ☐ Epilepsy/Seizures
- ☐ Gastric Reflux/Heartburn
- ☐ Hypertension (High blood pressure)
- ☐ Migraines
- ☐ Muscle Disease
- ☐ Nerve Disorder
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Other: _____

What are your goals related to therapy?

_____

_____

_____

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PATIENT FINANCIAL POLICY

Thank you for choosing Homer Physical Therapy. We understand that many patients find financial matters surrounding their medical care to be very complex and often times confusing. If you have any questions regarding our billing policies, we will be happy to assist you. **PLEASE READ CAREFULLY!!** Select only those which apply.

Private Health Insurance	**Initial Here** _____	We are ***NOT*** a contracted, "preferred", nor considered In-Network with most private health insurance plans. As the patient, **you are responsible** for requesting prior approval and/or Out of Network benefit level exceptions from your insurance company as required. Our office collects copayments due at the time of service. You will be billed for any amount not covered by your plan in addition to your deductible, and/or co-insurance amounts not collected at the time of service.
Medicare	**Initial Here** _____	We are a contracted provider with Medicare. You must be enrolled in Medicare Part B to be eligible for benefits. You will be billed for any remaining deductible, co-insurance amounts and/or patient-notified non-covered services after Medicare processes your claim. No payment is required at the time of service.
Medicaid	**Initial Here** _____	We are a contracted provider with Medicaid. You must present a current card for each month of eligibility. Please note, a referral is required if you are in the Lock-in Program; without a referral you will be considered a self-pay patient. Your co-pay is due at the time of service and failure to make payment may result in delayed future appointments.
Tricare / Triwest / VA	**Initial Here** _____	We are a non-network provider with Tricare and Triwest. We will bill Tricare and Triwest on your behalf as a courtesy. You will be responsible for any account balance not covered by your plan. VA visits must be preauthorized by your referring physician.
Workers Compensation	**Initial Here** _____	We only accept Workers' Compensation claims that were filed with the Alaska Departments of Labor. Your claim must be open and accepted. You must provide your carrier's information including claim number and date of injury. No payment is required at the time of service.
Self-Pay / Uninsured	**Initial Here** _____	Payment is due in full at the time of service unless other billing arrangements have been approved by Homer Physical Therapy.
Auto Accident	**Initial Here** _____	A claim must be established with your auto insurance carrier. We will only bill first party claims (your auto insurance policy) regardless of fault. Once your medical benefits are exhausted your private insurance may be billed. YOU MUST CONTACT YOUR PRIVATE INSURANCE TO DISCLOSE YOUR LIABILITY CLAIM. If you have no other insurance coverage, your account will be transferred to a self-pay status and payment will be due upon receipt unless other billing arrangements have been approved through Homer Physical Therapy.
Payment Plan	**Initial Here** _____	Payment Plans must be established through Homer Physical Therapy. Please note our payment plans are determined on an individual basis. All payments will be applied to the oldest date of service first.

- I have read, understood, and agree to this financial policy
- I understand that I am Ultimately responsible for my balance, not my insurance carrier
- I authorize Homer Physical Therapy to release medical information to my insurance carrier to facilitate payment.
- I understand that my signature authorizes benefits to be paid directly to Homer Physical Therapy.
- I understand that should my account balance become delinquent, the balance may be referred to a collection agency.
- I will be held responsible for all fees associated with the collection of my account balance.

Name of Patient: _____ Signature: _____

HOMER PHYSICAL THERAPY

PERSONAL & HEALTH INFORMATION PRIVACY POLICY

YOUR PERSONAL AND HEALTH INFORMATION

We understand that the privacy of your personal information is important to you. As your physician, we believe your right to privacy is a fundamental part of your treatment and as such would like to inform you of our privacy practices and procedures. This privacy notice describes how your personal and health information will be used and disclosed and how you can gain access to this information. Please read it carefully. Should you have any questions regarding these policies please do not hesitate to ask.

As part of our registration process, you and your family's personal and health information will be collected. This information is very important in the development of an effective treatment plan and we ask that you provide the most complete and accurate information as possible. Information such as; name, address, phone number, birth date, social security number, employer information, health history, insurance policy and coverage information will be collected from you and other health care entities you utilize. Throughout the course of your treatment we will also collect your health information regarding diagnosis, outside treatment plans, progress reports and any test lab results and or imaging studies you obtain from other health care facilities such as hospitals, laboratories, other physician offices, and imaging facilities.

HOW YOUR INFORMATION WILL BE USED

The personal and health information gathered may be used and disclosed with your general consent for purposes of treatment, payment, or routine healthcare operations. This means we may send your information to other physicians or facilities involved in your treatment as well as to your insurance company or a collection agency to obtain payment. Any other uses of personal and health information will only be used upon receipt of your written authorization. We do not sell your personal and health information to marketing or pharmaceutical companies. In certain cases of public health interest, we may be required to disclose certain information to local, state or national health organizations or government agencies. We may contact you to provide appointment reminders or information about treatment alternatives or other health related-benefits and services that may be of interest to you.

SAFEGUARDING YOUR PERSONAL AND HEALTH INFORMATION

We are required by law to (1) make sure that medical information that identifies you is kept private (2) provide you with our privacy policy (3) follow the terms laid out in the privacy policy. As a means of protecting your privacy, we restrict access to your personal and health information to only those employees who require the information to complete their jobs and provide quality service to you. We maintain physical, electronic and procedural safeguards to comply with state and federal regulations that guard your personal and health information. If you feel your privacy has been violated, you have the right to file a complaint with the Department of Health and Human Services. The complaint in no way influences your course of treatment. You have the right to request restrictions to our uses or disclosures of your personal or health information, although we are not required to agree to those restrictions. Once your request has been processed it will remain in effect until you request a change.

By signing below, I acknowledge I have read, understood, and agree to this Privacy Policy.

Patient Name (printed): _____ Signature: _____

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NO SHOW AND CANCELLATION POLICY

Homer Physical Therapy is committed to providing all our patients with exceptional care. We strive to be better than the top rehabilitation centers around the country and worldwide. When a patient cancels without giving enough notice, they prevent another patient form being seen. To serve you and others better:

PLEASE CALL OUR OFFICE BY 3:00 ON THE DAY PRIOR TO YOUR SCHEDULED APPOINTMENT TO NOTIFY US OF ANY CHANGES OR CANCELLATIONS.

TO CANCEL A MONDAY APPOINTMENT, PLEASE CALL OUR OFFICE BY 3:00 PM ON FRIDAY.

Failure to do so will result in a No Show. When a patient does not show up to their scheduled appointment, they also prevent another patient from being seen. The No Show policy is as follows:

1 NO SHOW – WARNING/REMINDER

2 NO SHOWS- $25 FEE

3 NO SHOWS- $25 FEE & FUTURE APPOINTMENTS CANCELLED.

By signing below, I understand that if I fail to make my appointments or fail to cancel on the day prior by 3:00pm, I risk a fee or cancellation of my future appointments. I, the undersigned, have read, understand, and agree to uphold this written policy concerning the No Shows and Cancellation Policy.

_____ _____

Printed Name Signature