21st Century Rehab, P.C.

Altoona Carlisle Indianola Physical Therapy Grimes Madrid

PATIENT INFORMATION FORM

Please print and complete ALL items. If an item doesn't apply, put N/A

Patient Legal Name: _____ **Age:** _____
last first middle

Address: _____
street city state zip

Email:_____

Home Phone: _____ **Work Phone:** _____ **Marital Status:** ____

Social Security #: _____ **Sex:** _____ **Date of Birth:** _____

Employer: _____**Full time student: yes___ no___**

Spouse's Name: _____ **SS#:** _____ **Date of Birth:** _____

Spouse's Employer: _____**Phone:** _____

Referring Doctor: _____***Phone:*** _____ ***Next Dr. appt.*** _____

Primary Care Physician:_____ **Phone:** _____

Person to notify in case of emergency OUTSIDE of household:

Name:_____ **Home Phone:** _____ **Work Phone:** _____

Address: _____
street city state zip

Injury History

Have you been treated here or by another physical therapist previously? Yes _____No _____

If yes, where? _____ **When?** _____

Was it for the same condition? Yes _____No _____If not, please specify: _____

Date of onset of current episode of symptoms/injuries/illness:_____

Place of injury: Home _____ School _____ Work _____ Auto _____ Other _____

Parts of BODY being treated for this injury:_____

Where did you hear about 21st Century Rehab?

☐ **Doctor Referral** ☐ **Newspaper** ☐ **Radio** ☐ **Friend/Family** ☐ **Other**_____

Please continue on next page.

Responsibility Information

Who will be primarily responsible for the bill?____

I will be paying my share of financial responsibility by: Cash ____ Check ____ Credit Card N/a

PRIMARY Insurance Company: _________________________________Phone #: ______________

Insurance Company address:____

Policy Holder's *Full* Name: ____

Policy Holder's ID #:__________________________________ Date of Birth: __________________

Relationship to Policy Holder____

Address: ____

Policy Holder's Employer: __________________________________Employer's Phone:__________

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Is there Secondary Insurance? Yes _____ No _____

Name of Secondary Insurance Company:____

Insurance Company Address:____

Policy Holder's *Full* name: ____

Policy Holder's ID#:_______________________________________ Date of Birth: _____________

Relationship to Policy Holder:____

Policy Holder's Employer: ___________________________________Employer's Phone__________

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ARE YOU CURRENTLY or HAVE YOU RECENTLY RECEIVED ANY HOMEHEALTH CARE?

Yes ___ No ___ Dates of Service: ____________________

Name of Agency: _________________________________ Phone Number: ____________________

IS THIS A WORKER'S COMPENSATION CLAIM? Yes ___ No ___ Date of Injury: _______

Company: ____________________________ Address: ______________________________________

Phone Number: _____________ Claim #: ______________Contact Person: __________________

IS THIS AN ACCIDENT CASE? Yes ___ No ___ VEHICLE ___ OTHER _________________

Insurance Company to Bill: ____

Address: ____

Phone #: ________________________________Case #:_______________________________________

Adjuster Name: ____

Is there an attorney involved in your case? Yes _____ No ____

Attorney's Name: ____ Phone: ______________________

Address: ____

21st Century Rehab, P.C.

Consent to Medical Care

I consent to the therapy rendered to me(or the person for whom I am legally responsible) that is determined to be necessary by the therapist and/or physician.

Financial Agreement

I agree to pay for the services rendered to me (or the person for whom I am legally responsible, either directly or through my insurance or third party payer(s). If through a third party payer, I hereby assign all the benefits payable for this care, to the provider. I also agree to pay directly for any services not covered by my third party payer(s). Our office requires a 24-hour notice for cancellation of appointments; you can call and leave a message on the answering machine if needed. We realize conflicts with work, other activities, or unexpected illness may require you to call and reschedule; however, there will be a $25.00 charge for a missed appointment without notification to the office. For liability cases, where another party is responsible, you need to provide us with all the billing information. If you have an attorney, please provide this information on the registration form. It is this office's policy that a letter of protection must be received from your attorney within the first 2 weeks of your treatment. Without this letter, you become responsible for the account in full.

Release of Medical Information

I hereby authorize the provider to release to my insurance company (companies) or third party payer(s) all medical information needed to substantiate payment for the care to me (or the person for whom I am legally responsible) and permit representatives to examine and make copies of records relating to such care and treatment.

ACKNOWLEDGMENT OF RECEIPT OFPROVIDER'S NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge that I have received a copy of 21st Century Rehab, P. C.'s Notice of Privacy Practices which summarizes the ways my identifiable health information may be used and disclosed by Provider and states my rights with respect to my medical information. I understand Provider has the right to revise these information practices and to amend the Notice of Privacy Practices. I have been informed that in the event Provider revises its information practices, a revised Notice will be posted at 21st Century Rehab Clinics and that I may obtain a current Notice of Privacy Practices at any time from Jason Horras at 515-382-3366.

SIGNATURE: _____ DATE: _____

Signature for Minor (under 18 years of age): _____

RECEPTIONIST INITIALS _____

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For Office Use Only: Date of Birth: _____ Onset Date:_____

Therapist:_____ Referral Date:_____

Diagnosis_____ ICD-9_____
(can not use V67.0 for diagnosis)

Physician_____ Physician UPIN_____

Physician Address_____
street city state zip