Great Basin
Physical Therapy
and
Performance Center

Patient Information Sheet

Name:_____Date of Birth:_____ Age:_____

Physical Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell Phone:_____E Mail Address:_____

Employer:_____ Work Phone:_____

Primary Care Physician: _____

Mailing Address (if different from above):_____

City: _____ State: _____ Zip Code: _____

Emergency Contact Information

Name:_____Relation to Patient:_____

Phone Number:_____

Mission Statement

Our goal is to provide quality physical rehabilitation to help patients recover from pain, reach the maximum potential for their physical needs, and return to the active lifestyles that they enjoy in Douglas County. We strongly believe in promoting overall wellness and injury prevention. Our physical therapists perform a comprehensive evaluation and design customized treatment programs to meet each of our patient's specific goals. Our physical therapists are committed to ongoing and continuing education to ensure professional growth. Some physical therapists will have obtained additional certifications that require years of consistent dedication to secure and maintain. It is this combination of clinical expertise, genuine caring, and a strong community reputation that will sets Great Basin Physical Therapy apart, making us the rehabilitation choice for doctors, patients, and the community.

Patient Signature:_____ **Date:**_____

Your First Visit

We require completion of a patient intake packet when you arrive for your first visit, which is attached to this letter. The intake packet consists of forms requesting basic patient information, your authorization to release medical records to your doctor, and a health questionnaire. It is very important that you fill all of these forms out completely and to the best of your ability so that we can make your experience with us as pleasant as possible by providing superior medical treatment. Your initial evaluation will take approximately 1 hour and will consist of one-on-one time with our highly trained physical therapists.

Your Future Appointments

Every patient is required to stop at the reception desk upon completion of each visit in order to schedule future appointments and or take care of any payments that need to be made. We kindly request that you make every effort to give us 24 hour notice if you should need to cancel or reschedule your appointment. Since we strive to get patients treated as efficiently and effectively as possible, every time slot is very valuable and timely cancellations are of the utmost importance. ***Cancellations made in less than 24 hours and No Shows may be subject to a $65 fee.***

Please Initial _____

***** Please Note: An excessive number of No Shows/Cancellations (2 or more) may result in discharge from Great Basin Physical Therapy. Your attendance is greatly appreciated.***

Please Initial_____

Co-Pay and Co-Insurance Payments

What is a co-pay?

"A co-pay is a type of insurance policy where the insured pays a specified amount of out-of-pocket expenses for health-care services such as doctor visits and prescriptions drugs at the time the service is rendered, with the insurer paying the remaining costs. However, unlike coinsurance where the insured is required to pay a certain percentage of the covered costs, co-pay plans require the insured to pay a specified dollar amount."

What is a co-insurance?

"A co-insurance is a co-sharing agreement between the insured and the insurer under a health-insurance policy which provides that the insured will cover a set percentage of the covered costs after the deductible has been paid. Similar to co-pay insurance plans except co-pays require the insured to pay a set dollar amount at the time the service is rendered."

If you have a co-pay or a co-insurance, please plan on making your payments after each treatment as payment is due after the service has been rendered. For your convenience, we accept cash, check or cards Visa, MasterCard, Discover, and American Express. A 4% service fee will be assessed for non- cash or check transactions.

By signing below, I acknowledge that I have read and accept the policies and procedures of Great Basin Physical Therapy and will make every effort to adhere by said policies and procedure.

Signature of patient or legal representative: _____ Date: _____

PATIENT INFORMATION & AGREEMENT

Fees & Insurance

If a patient has medical insurance, this office will bill the insurance carrier. Verification of insurance coverage and limits, as well as approvals for industrial injury cases are performed routinely by this office. All insurances are verified prior to your initial visit; however, this is not a guarantee of payment by your insurance. All charges are ultimately the responsibility of the patient regardless of insurance coverage, unless, the carrier is worker's compensation. If the worker's compensation, by their determination, denies the claim, the patient will then be responsible. It is the policy of Great Basin Physical Therapy and Performance Center, to collect co-payments, co-insurance and deductible amounts at the time of service. Patients that do not have insurance are required to pay in full at time of services.

Release of Information

The undersigned agrees that, to the extent necessary to determine liability for payment and to obtain reimbursement, this office may disclose portions of the patient's record, including his/her medical records, to any person or corporation which is or may be liable for all or any portion of the charges, including but not limited to insurance companies, health care service plans, worker's compensation carriers, the patient's employer, health care providers and utilization review monitoring organizations.

Financial Agreement

The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the amount of Great Basin Physical Therapy charges. Should the account be referred to an attorney or collection agency the undersigned shall pay actual attorney's fees and collection expenses. All accounts may bare interest at the legal rate.

Appointments

If a cancellation is necessary, an attempt will be made to schedule another appointment the same day so the recommended number of weekly appointments can be kept. Should treatments involve an industrial injury, this office is required to notify the industrial carrier of any missed appointments.

Please sign below to acknowledge understanding & agreement with the policies:

_____ _____

Signature of Patient or Legal Representative Please Print Name of Person Signing

_____

Date

****We have verified your insurance benefits; however, this does not guarantee payment from your insurance company.**

Please initial: _____

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name:_____ Date of Birth: _____

Previous Name:_____ Social Security No:_____

I request and authorize Great Basin Physical Therapy and Performance Center to release health care information of the patient named above to the following:

Name:

_____

_____

This request and authorization applies to:

[ ] Health care information relating to the following treatment, condition or dates:

_____

[ ] All health care information

[ ] Other: _____

Your Rights

- I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment or payment.
- I may revoke this authorization at any time by signing the revocation section of this form and returning it to this office.
- My revocation will be effective upon receipt, but will have no impact on uses or disclosures made while my authorization was valid.
- I have a right to receive a copy of this authorization. If this box [ ] is checked, copy was requested and received. *Initials* _____
- I may inspect and obtain a copy of the health information that I am authorizing for use or disclosure.

Name (please print):_____ Phone: _____

Signature of patient/legal representative: _____ Date: _____

If not signed by the patient, please indicate relationship:

[ ] Parent or guardian of minor patient

[ ] Beneficiary or representative

[ ] Guardian or conservator of an incompetent patient

[ ] Other (please specify):_____

REVOCATION SECTION

I hereby revoke this authorization.

Signature:_____

Date:_____

You Must Understand Your Own Health Insurance Plan

Due to the complexity of all the new health insurance plans offered today, it is the responsibility of every patient to ensure that they fully understand the terms of their medical insurance plan, including:

- In network providers
- Covered services
- Co-Payments, deductibles and out of pocket maximums

It is also the responsibility of every patient to notify this office of any changes in their medical insurance. Failure to do so may limit the ability of this office to properly bill your insurance and result in full costs of office visits and procedures being forwarded to you, the patient.

Signature of patient/legal representative:_____ **Date:**_____

PATIENT ACKNOWLEDGEMENT

I acknowledge that I have received and reviewed the summary of the Notice of Privacy Practices, which provides a description of information uses and disclosures. I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that Great Basin Physical Therapy and Performance Center is not always required to agree to the restrictions I request. I also understand that I may obtain a full copy of the Notice of Privacy Practices.

_____
Signature of Patient or Legal Representative

_____
Witness

_____
Please Print Name of Person Signing

_____
Date

_____
Date

Great Basin Physical Therapy and Performance Center

Patient Intake Form

Patient Name:_____ DOB:_____ Age:_____ Date:_____

Occupation:_____ Date of Injury:_____ Date of Surgery:_____

Are you receiving Home Health Care?_____ Height: _____ Weight: _____

Are you currently pregnant?_____

What caused your current problem?_____

Have had this problem before? O Yes O No If Yes when and where?_____

Have your symptoms gotten worse? O Yes O No

Tobacco use? O Yes O No How often? _____

What makes your symptoms better?_____

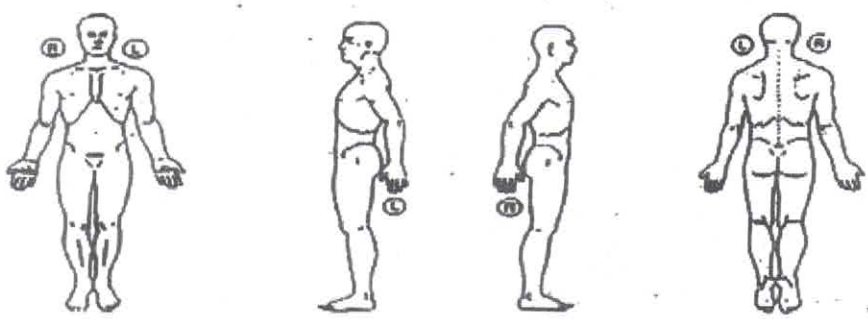
What makes your symptoms worse?_____

Are you able to sleep with this problem? O Yes O No O Sometimes

Is your pain worse in the: O Morning O Midday O Evening O All day

List **all** medications you are currently taking:_____

Your pain: Draw the areas of pain (////) ; tingling (XXXX) ; numbness (>>>>)



Tests Performed (check all that apply) O X-Ray O MRI O Epidural O Cortisone O Other:_____

Past Medical History (Major illness and surgeries):_____

_____

Do you now or in the past have you had problems with (check all that apply):

O Allergies	O Osteoarthritis	O Rheumatoid Arthritis	O Cancer:
O Joint pain	O Diabetes	O Head Injury	O Heart problems
O Stroke	O Heart Attack	O Seizures	O Blood Pressure
O Head Aches	O Thyroid	O MS	O Asthma
O Osteoporosis	O Balance Issues	O Pacemaker	O Parkinson's
O Defibrillator	O Other:_____		

Who were you referred by? _____

What are your Physical Therapy Goals?

O Decrease pain O Increase strength O Increase endurance O Increase range of motion

O Return to work O Return to prior level of function O Return to sport activities ( )

O Other pertinent information:_____

Patients Initials:_____ Therapist Initials: _____