Physical Therapy at Oakdale

Patient Information Form

Patient Information

Last Name _____ First Name _____ MI _____

Address _____

Address2 _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Date of Birth _____ Gender _____ Marital Status _____ Email _____

Emergency Contact

Last Name _____ Relationship _____

First Name _____ Phone _____

Problem

Problem Description _____ Date of Injury _____ Last Physician Visit / /

Referred By _____ Primary Care Physician _____

Notes: _____

Primary Insurance

Insurance _____ Deductible _____

ID _____ Max Benefit _____

CoPay _____ CoInsurance _____

Subscriber

Name _____

Relationship _____

Date of Birth _____

Secondary Insurance

Insurance _____ Deductible _____

ID _____ Max Benefit _____

CoPay _____ CoInsurance _____

Subscriber

Name _____

Relationship _____

Date of Birth _____

* I authorize release of information requested by my insurance plan for payment. * I understand that I am financially responsible for any balance due.
* I agree to comply with the terms & conditions as outlined on the Patient Registration form.

I hereby acknowledge that I have been informed of Oakdale Physical Therapy & Fitness's Notice of Privacy Practices & Cancellation Policy regarding cancellation fees.

Signature: _____ Date: _____

(if minor parent or guardian signature)

CANCELLATION / NO SHOW / LATE POLICY

Our goal is to provide quality care in a timely manner. In order to do so we have had to implement an appointment Cancellation/No Show Policy. This policy enables us to better utilize available appointments for our patients in need of our care. We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel & we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

Please note that Oakdale Physical Therapy & Fitness has a 24 hour cancellation policy. You may be charged a fee of $25 should you not provide the required 24 hour notice of cancellation or NO SHOW to your scheduled appointment. This fee will be charged directly to you for non compliance not to your insurance company & payable prior to your next scheduled appointment. If you are more than 10 minutes late to your scheduled appointment you may be asked to reschedule your appointment by your physical therapist as to not disrupt their schedule or the schedule of other patients. More information regarding this policy can be found in the white binder in our waiting area. Should you need a copy please request one from our front desk.

THANK YOU we appreciate your assistance on this matter. →

Oakdale PTF Patient Questionnaire

Past/Present medical conditions (circle answers for each line below):

Asthma	No/Past/Present/Family	Epilepsy/Seizures	No/Past/Present/Family	Kidney Disease	No/Past/Present/Family
Arthritis	No/Past/Present/Family	Extremity Swelling	No/Past/Present/Family	Metal/Other implants	No/Past/Present/Family
Bowel Dysfunction	No/Past/Present/Family	Fainting	No/Past/Present/Family	Multiple Sclerosis	No/Past/Present/Family
Cancer	No/Past/Present/Family	Fever/Chills	No/Past/Present/Family	Osteopenia/Osteoporosis	No/Past/Present/Family
Chemical Dependency	No/Past/Present/Family	Fibromyalgia	No/Past/Present/Family	Pacemaker	No/Past/Present/Family
Chest Pain/Discomfort	No/Past/Present/Family	Fracture	No/Past/Present/Family	Pregnancy	No/Past/Present/Family
Circulatory Disease	No/Past/Present/Family	Headache	No/Past/Present/Family	Shortness of Breath	No/Past/Present/Family
Depression	No/Past/Present/Family	Heart Attack	No/Past/Present/Family	Stroke	No/Past/Present/Family
Diabetes	No/Past/Present/Family	Heart Disease	No/Past/Present/Family	Thyroid Problems	No/Past/Present/Family
Dizziness	No/Past/Present/Family	Hepatitis	No/Past/Present/Family	Visual Impairments	No/Past/Present/Family
Difficulty Urinating	No/Past/Present/Family	Hernia	No/Past/Present/Family	Unexplained weight change	No/Past/Present/Family
Eating Disorder	No/Past/Present/Family	High Blood Pressure	No/Past/Present/Family	Urinary frequency changes	No/Past/Present/Family
Emphysema	No/Past/Present/Family	Infectious Disease	No/Past/Present/Family	Other_____	No/Past/Present/Family

Are you currently receiving physical therapy @ another office for any issue? Yes ___ No ___ For? _____

Medical /Surgical History (Sprains, fractures, illnesses, etc): _____

_____

Medications / supplements (Include current list and past long -term use): _____

_____

Allergies and Reactions: Check here if none ☐_____

Do you use: Tobacco Yes/No Frequency_____ Caffeine Yes/No Freq _____ Alcohol Yes/No Freq _____

X-Ray Y/N: When/Where_____ (for this issue ONLY) MRI: Y/N When/Where _____ (for this issue ONLY) CT Scan: Y/N When/Where_____ (for this issue ONLY)

Current Condition: What injury / problem / complaint has brought you to physical therapy today: _____

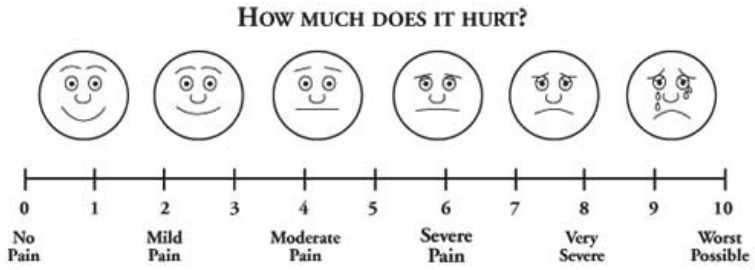
_____

When and how did this problem begin: _____

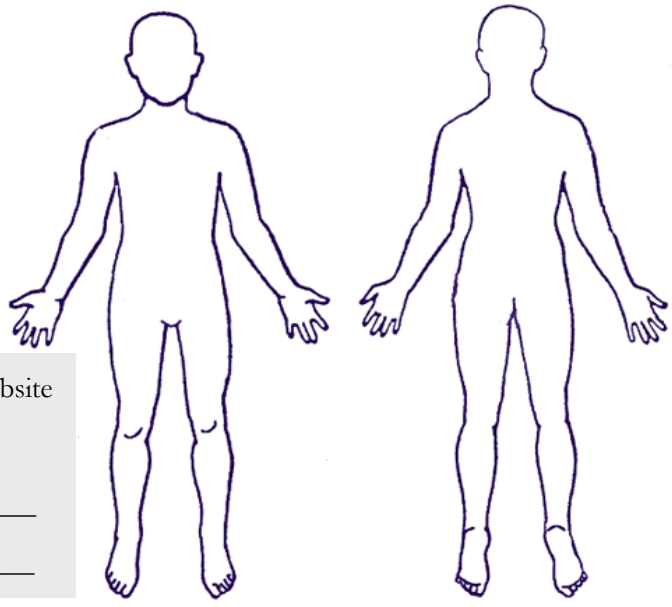
Is this problem keeping you from something you **love** doing? (What?)_____

What makes it better:_____ Worse: _____ Location of pain: _____

What products / supplements are you using to help your problem get better? _____



Please rate pain level above on scale and mark area(s) of pain on image to right.



How did you hear about our office? ☐ Dr's Office ☐ TV ☐ Website

☐ Because you are a Court Jester Member: West of East? (Circle one)

☐ Facebook ☐ Phonebook ☐ Other _____

☐ Word of mouth (Name) _____

TO OBTAIN AND RELEASE MEDICAL INFORMATION:

This signed document, copy of same, will authorize you to furnish Oakdale Physical Therapy & Fitness, or its representative, any or all information in your possession regarding the below-named patient's condition while under your care or treatment, including the history obtained, diagnostic imaging (i.e.: x-ray, MRI, etc…) (includes obtaining copy of original films/discs), physical and laboratory findings, diagnosis and prognosis.

THIS BOX OFFICE USE ONLY

☐ OP REPORT ☐ MRI ☐ XRAY REPORT ☐ CT SCAN ☐ OTHER_____

PATIENT PRINT NAME: _____DOB: _____

PATIENT SIGNATURE: _____ Date: _____

(if minor parent or guardian signature)

HIPPA

You can find all our HIPPA Policies located in a binder in our waiting area for your review. Should you need a copy please request one from our front desk. Please sign that you have been made aware of Oakdale Physical Therapy & Fitness' HIPPA compliance policies.

CANCELLATION / NO SHOW POLICY

Please note that Oakdale Physical Therapy & Fitness has a 24 hour cancellation policy. You may be charged an additional fee of $25 should you not provide the required 24 hour notice of cancellation or NO SHOW. More information regarding our policy can be found in the white binder in our waiting area. Should you need a copy please request one from our front desk. Please note your account is required to be in good standing to make subsequent physical therapy appointments.

ASSIGNMENTS OF INSURANCE BENEFITS AND PATIENT RESPONSIBILITY

By signing this form, I authorize Oakdale Physical Therapy and Fitness to submit medical claims on my behalf to my insurance provider. I understand and acknowledge that submission of claims is not a guarantee of payment. I understand that it is my responsibility to notify Oakdale Physical Therapy & Fitness of any changes to my insurance carrier or coverage as soon as possible. Any failure to report such changes will result in the patient being financially responsible for any lapse in coverage or authorization. If for any reason my carrier does not cover any and/or all of my physical therapy treatments, I agree that I am responsible for the payment of the entire amount. We require **ALL CO-PAYS, DEDUCTIBLES & CO-INSURANCES be paid at time of service.** More information regarding our policy can be found in the white binder in our waiting area. Should you need a copy please request one from our front desk.

Oakdale PT & Fitness is not responsible for property that is left unmonitored. Patients and clients shall be responsible for their personal items at all times. Although items left in the waiting room are relatively safe from theft or damage, they are not the responsibility of the company.

I understand that I have the right to obtain a copy of Oakdale Physical Therapy & Fitness Notice of Privacy Practices and any files as stated above.

_____ _____

PRINTED NAME OF PATIENT **SIGNATURE OF PATIENT (or Parent/Guardian)**

Oakdale Physical Therapy & Fitness Financial Policy and Agreement

The following is an explanation of Oakdale Physical Therapy & Fitness' financial policy & agreement, which we ask you to read then sign prior to any evaluation & treatment.

Initial Here *(each line)*

_____ As a courtesy, this office will submit bills to your insurance carrier. In order to facilitate claims processing, you must provide all insurance policy information and changes to our office. It is the patient's responsibility to know what the insurance company will allow for physical therapy. Your contract with your insurance company is between you & them, not us.

_____ INSURANCE COVERAGE IS NEVER GUARANTEED. Your insurance company determines benefits when claims are received. Any quotes of benefits or coverage made by staff of Oakdale Physical Therapy & Fitness, in no way guarantees payment by your insurance company. You will be responsible for any balances not paid by your insurance.

_____ CO-PAYS ARE DUE AT EACH VISIT. Co-pays are based on your direct contract between you and your insurance company. By law we can not waive co-pays.

_____ WE CANNOT BILL YOU FOR A CO-PAY. They are due at each visit, at check in.

_____ Should a parent not accompany their child to therapy, they need to send payment with them or make arrangements with the billing office to charge it to a credit card.

_____ High deductible plans require a $50.00 payment towards each visit costs. This is an estimate only, not an exact figure. There is a high likelihood that you may still be responsible for an additional balance once your insurance has processed your claim.

_____ Patients with CO-INSURANCE will be required to pay at time of service. This is an estimate only and there may be an additional balance once your insurance has processed your claim.

_____ Your bill is your responsibility, whether your insurance company pays or not. At times, you may need to contact your insurance carrier regarding slow or non-payment of your insurance claim.

_____ **Failure to give 24 hours notice of cancellation or No Show can result in a $25.00 charged billed directly to you, not your insurance company per episode & payable prior to your next scheduled appointment. If you fail to attend three appointments, either by failing to show up for your appointment, or not giving sufficient cancellation notice, you may be discharged by our practice.**

We do participate with most insurance companies. However, some plans require a referral from your primary care physician. A written referral and any required preauthorization must be on file prior to each office visit.

Patients who do not have medical insurance are required to pay the total balance at time of each visit.

Statements are sent out once a month. Patients are expected to pay account balances in full each month.

Patients who do not remit payment within 30 days of receiving their first statement will be contacted by our billing department. You will be required to pay your balance prior to your next scheduled appointment. Accounts that have not been paid within 90 days will be sent to an outside collection agency.

Patients whose accounts have been sent to the collection agency will forfeit the opportunity to be treated in the future.

Account balances must be paid in full prior to the onset of a new course of treatment.

Please be on time for your appointments - if you are late, your treatment time may be shortened or may be rescheduled.

Supplies: Supplies purchased by the patient are payable at the time of service. Supplies are not returnable or refundable. WE DO NOT BILL INSURANCES FOR SUPPLIES.

We accept Cash, Checks, and Credit Cards - Our Billing Office Staff are willing to help you with explanation of charges and insurance payments. Please contact them at 607-217-0827.

We look forward to helping you get back to what you love doing!

Print Name: _____ Date: _____

Signature: _____ Relationship: _____

(if patient is a minor parent or guardian must sign as responsible party)