WELCOME TO GIDDINGS PHYSICAL THERAPY CLINIC
Also doing business as Elgin Physical Therapy

Name: _____ SS#:_____

Date of Birth: _____ Age:_____ Marital Status:_____

Physical Address: _____ City/State/Zip: _____

Mailing Address (if different):_____ City/State/Zip: _____

Phone (H):_____ (W)_____ (Cell)_____

Employer: _____ Phone:_____

Job Title: _____ Full Time: □ Part Time: □

Spouse or parent's name (if minor child): _____

Spouse/Parent's Employer/Address: _____

Phone (H): _____ (W):_____Cell:_____

Area to be treated: _____ Work injury: □ Yes □ No

Date of Injury: _____ Date of Surgery: _____

Referring Physician: _____ Date of next apt: _____

INSURANCE INFORMATION:

Insurance Company: □ Medicare □ Medicaid □ BCBS □ Cigna □Humana □ Worker's Comp

□ UnitedHealth Care □ Aetna □ Auto _____

Other: _____ Secondary Coverage: _____

Subscriber name: _____Relationship to Patient: _____

DOB: _____ SS#:_____ Employer: _____

EMERGENCY CONTACT

Name: _____Relationship:_____

Phone: _____ Work: _____ Cell:_____

PATIENT AGREEMENT – ASSIGNMENT AND RELEASE

I, undersigned, have insurance coverage with and assign directly to Giddings Physical Clinic, dba Elgin Physical Therapy Clinic, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize release of information necessary to file a claim with my insurance.

Patient's Signature: _____

Witness: _____Date:_____

INITIAL HISTORY INFORMATION

Please check all that apply:

	Now	In the Past		Now	In the Past
Anxiety	□	□	Anemia	□	□
Asthma	□	□	Cancer	□	□
Depression	□	□	Head Injury	□	□
Diabetes	□	□	Heart Disease	□	□
Dizziness/Fainting	□	□	Hepatitis	□	□
Fibromyalgia	□	□	High Blood Pressure	□	□
Hearing	□	□	Osteoarthritis	□	□
Mental Disorders	□	□	Osteoporosis	□	□
Seizures	□	□	RA	□	□
Stroke	□	□	Shortness of Breath	□	□
Urinary Problems	□	□	Swollen Ankles	□	□
Visual Problems	□	□	Tuberculosis	□	□
Pacemaker	□	□	Arrhythmias	□	□
Thrombosis (clot)	□	□	Thrombophlebitis (clot)	□	□
Metal Implants	□	□	Defibrillator	□	□

Other:_____

Please let the therapist know if you are pregnant or think you may be pregnant.

What would you like to achieve as a result of therapy?

_____

Patient Signature

Giddings Physical Therapy Clinic, Inc.
Also doing business as Elgin Physical Therapy Clinic

Privacy Practices Acknowledgement

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it. The Notice describes how my medical information may be used and disclosed and how I can get access to this information. I understand that I have the right to the confidentiality of my medical information and this practice is required by law to maintain the privacy of that information. In order for this practice to keep your information as confidential as possible please check the boxes below regarding the ways you wish to be contacted.

- Home Telephone_____
  - OK to leave message with detail information
  - Leave message with call back number only.
- Work Telephone_____
  - OK to leave message with detail information
  - Leave message with call back number only

We automatically release information regarding your care to the referring doctor and to your insurance company (as needed), however, if you wish for us to discuss your care with anyone else including your spouse, children or others please list the names below.

_____ _____

_____ _____

_____ _____
Printed Name Signature and Date

PATIENT RIGHTS

- To be treated with respect and dignity.
- To be informed of his/her care needs in order to make appropriate decisions.
- To expect a reasonable safe environment.
- To help plan his/her care and make changes to it.
- To expect that teaching materials and aids will be written or presented in a manner that can be understood.
- To be informed of the office billing process.
- To have access to medical records.
- To have records kept confidential beyond the office except when express consent has been given.
- To expect that services be provided in a timely manner.
- To know the professional status of their caregiver.
- To have another agency contacted if needed services are not available through this office.
- To refuse services.
- To communicate complaints to the office manager and expect to receive a follow-up without negative repercussions or changes in services.
- To receive care without discrimination because of race, religion, age, sex, disability or ethnic origin.
- To expect office personnel to be qualified and competent in all respects to perform the services that are provided.

_____ _____
Patient Signature Date

Financial Policies

With all our patients, our goal is to provide the best possible care. However, to avoid misunderstandings we have clarified our policies below.

Insurance Filing – As a courtesy to our patients we do file insurance for your visits. We also make every effort to verify your benefits and ask that you do the same so that you are informed of your coverage. **Knowing your insurance benefits is your responsibility.**

Insurance Coverage – We are providers for most insurance plans and we accept Medicare and Medicaid. Please advise the office staff if you have an automobile or other third party liability claims (accident policies, litigations, etc.). Depending on the circumstances we may not be able to file these claims. You are responsible for the portion of your charges that are not covered by insurance. Please contact your insurance company with any questions about your coverage or claims processing.

Proof of Insurance – All patients must complete our patient information form before seeing the therapist. We must obtain a copy of your driver's license and current valid proof of insurance. Please notify us as soon as possible if your insurance changes while you are being treated.

Co-Payments and Balances – Co-payments are due at each visit. Your co-insurance is due upon receipt of your statement. If you cannot pay your deductible, co-payments or co-insurance, we do offer financial agreements, which will allow you to make monthly payments. Please check with the office staff if you wish to make financial arrangements.

Interest – Unless you have signed a financial agreement all unpaid balances, after 3 billing cycles will have 18% interest per year, or 1.5% interest added per month.

Non-payment – Statements are due and payable in full upon receipt as well as payments per your financial agreement. If your balance remains outstanding we will refer your account to small claims court. If we must take this action you will be responsible for the payment and all associated court costs.

Elgin Physical Therapy – For Elgin patients please note: we are owned by Giddings Physical Therapy, doing business as Elgin Physical Therapy. On your statements and EOBs from your insurance company the name Giddings Physical Therapy may be noted.

Please let us know if you have any questions or concerns.

I have read and understand the financial policies and agree to abide by all guidelines:

_____
Printed name of patient or responsible party

_____ _____
Signature of patient or responsible party Date