Witte PHYSICAL THERAPY

DEMOGRAPHICS

Date: _______________ Male/Female Birthdate: ___ / ___ / ___ Age: ____

Last Name: ________________________ First Name: _______________________ MI: _____

Physical and Mailing Address: ____

City: _______________________________________ State: ________ Zip Code: ___________

Banking Institution: _________________________ SSN: _________________________________

Marital Status: Single Married Divorced Widowed Student

Home Phone: __________________ Cell: __________________ Work: ___________________

Parent/Guarantor Email Address (appointment reminders, billing statements):
____

Parent/Guarantor Employer: ____________________________ Occupation: _________________

Employer Address: _________________________________ City: _____________ Zip: ________

Physician Referred By: ____

Spouse, Parent, or In Case of Emergency Contact Name: _________________________________

Address: ____ City: ____________ Zip: ________

Home Phone: __________________ Cell: __________________ Work: ___________________

Employer: _____________________________Occupation: ________________________________

Employer Address: _________________________________ City: _____________ Zip: ________

Email: ____

Banking Institution: ___________________________ SSN: ______________________________

INSURANCE INFORMATION

Name of Insured (Policy Holder): ______________________Relationship to Patient:_________

Policy Holder DOB: ___________   Policy Holder SSN: _________________

Do you have secondary insurance coverage? Y or N, if yes then complete the following:

Name of Insured (Policy Holder): ______________________Relationship to Patient:_________

Policy Holder DOB: ___________   Policy Holder SSN: _________________

AUTHORIZATION AND RELEASE

I certify that the information provided above is true and correct to the best of my knowledge and belief.
I authorize this company to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period such care to third party payors and/or health care providers. I authorize and request my insurance company to pay directly to the physical therapist's office, insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I understand I am responsible for all copays, deductibles, co-insurance, and balances. I understand and agree that I am ultimately responsible for any unpaid balances. I understand and agree that any cellular or land line phone numbers and email addresses provided by myself to this office and to any of our service providers, now and in the future, may be used as means to contact me, and that this office and our service providers may leave messages for my manually and by using automatic systems such as by artificial or prerecorded voice. By signing this Authorization, I agree that this office, and any third parties used for treatment, billing, collection, and other services may use any means of communication with me. Specifically, if I proved a cellular phone number, I consent and agree to accept collection calls and other communications to my cellular phone from this office and from an of our service providers. I also agree that this office and any service providers may contact me by sending text messages and emails to any phone number or email address I provide to this office or service providers. I consent to receive such text messages and emails which may identify the name of this office or service provider sending the communication, and which may disclose the nature of the communication.

Signature of Patient/Guarantor:

____

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PERSONAL HEALTH HISTORY

Name: ____________________________________ Height: _________ Weight: ________

Referring Physician: _________________________________

What are we seeing you for today: ______________________________

How this injury occurred: ____

Where did this injury occur: ______________________ Date of Injury: ___ / ___ / _____

Where you treated in an emergency room: Y N If Yes, Where: __________________

Have you had an X Ray or MRI: Y N If Yes, Where: ________________________

Are you currently Pregnant: Yes No

Do you smoke: Yes No If Yes, how many packs per day: ____________

Do you have any allergies: Y N If Yes, please list: __________________________________

Have you fallen in the past year: YesNo If Yes, how many times: ___________

If you have fallen, were you injured: Yes No
If Yes, please explain:
____

Have you recently or are you currently receiving home health care or physical therapy care:
Yes No

Have you received physical therapy care in this calendar year: Yes No

Circle any you have or may have:

Arthritis Osteoarthritis Rheumatoid Arthritis Osteoporosis Epilepsy Diabetes

Kidney Disease Liver Disease Rheumatic Fever Cancer: __________________________

Stomach Ulcers Cortisone Drugs Heart Disease Chest Pain Anemia

High Blood Pressure Stroke/TIA Depression Polio Tuberculosis Asthma

Chronic Bronchitis COPD/Emphysema Peripheral Neuropathy Diabetic Ulcer

Peripheral Artery Disease Other: ____

Past Surgeries (Year):

____

____

____

Medications:

Name: __________________________ Dose: ______ Frequency: ________ Route: _____________
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CONSENT TO TREATMENT

1. CONSENT TO TREATMENT
I, knowing that I have a condition requiring diagnosis, treatment, or related care do hereby consent to such care, physical therapy examination, procedures, interventions, and/or treatment by a physical therapist, their assistants or aides, as may be necessary in their professional judgment. I further acknowledge that no guarantees have been made to me as to the results of such care, physical therapy examinations, procedures, and/or interventions. I also authorize release of such information to the third party payor(s).

1. ASSIGNMENTS OF BENEFITS
I hereby assign to Witte Physical Therapy and to all therapists providing treatment(s) all right, title, and interest, in and to the benefits payable affording clinic and therapist's coverage. I direct that such benefits be paid directly to said clinic and therapists.

2. INSURANCE PRE-CERTIFICATION INFORMATION
Many insurance companies have pre-certification requirements for physical therapy. If you are not sure whether your insurance company had pre-certification requirements, please check before evaluation and/or treatment so that you will not be denied insurance benefits for this/these visit(s).

3. AUTHORIZATION FOR RELEASE OF INFORMATION
I hereby authorize Witte Physical Therapy to furnish records from any treatments, photocopies of such records and/or information, and excerpts from such records to the attending physician, his/her associates, and/or consultants, and third party payor (whether an insurance company, government agency, or self insured employer) and/or any transferee health care facility and/or agency for the purposes of obtaining payment for services rendered while under clinic care, performing utilization review, and/or post care and treatment. If this is a work related injury I authorize Witte Physical Therapy to provide my employer with any and all needed information related to my condition. Finally, if further care from another therapist, physician, or specialist were needed I authorize the release of my records to such a party.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE FOREGOING, AND IS THE PATIENT, OR IS DULY AUTHORIZED BY OR IN BEHALF OF THE PATIENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS.
Responsible Patient/Party/Insured: ____

Responsible Patient/Party/Insured: ____

Witness: ____

Date and Time: ____

CONSENT TO TELEHEALTH

4. INTRODUCTION OF TELEHEALTH
Telehealth is the delivery of healthcare services when the healthcare provider and the patient are not in the same physical location using technology. Electronically transmitted information may be used for diagnosis, therapy, follow-up, and/or patient education and may include patient medical records, medical images, interactive audio, video, and/or data communications, and output data from medical devices. The interactive electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

5. RISKS
Risks may include, but are not limited to:
   - Information transmitted may not be sufficient to allow for appropriate medical decision making by the physical therapist or physical therapist assistant
   - The physical therapist or physical therapist assistant may not be able to provide medical treatment through the use of telehealth equipment nor provide for or arrange for any emergency care that may be required
   - Delays in evaluation and treatment could occur due to deficiencies or failures of equipment
   - Security protocols could fail causing a breach of privacy of personal medical information

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE FOREGOING, AND IS THE PATIENT, OR IS DULY AUTHORIZED BY OR IN BEHALF OF THE PATIENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS.

Responsible Patient/Party/Insured: ____

Responsible Patient/Party/Insured: ____

Witness: ____

Date and Time: ____

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CONSENT FOR MEDICAL PHOTOGRAPHY

I consent for medical imaging (phone, video, and/our audio) to be made of me, my child, or the person whom I am a legal guardian for. I understand that the information may be used in my/their medical record, for purposes of medical teaching at Witte Physical Therapy, or for publication in marketing tools in print or on Witte Physical Therapy social media accounts (Facebook, Twitter, Instagram). By consenting to this medical photography, I understand that I will not receive payment from any party. Refusal to consent to photographs, video, and/or audio recordings will in no way affect the medical care I will receive. If I have any questions or wish to withdraw my consent in the future, I may contact the staff at Witte Physical Therapy.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE FOREGOING, AND IS THE PATIENT, OR IS DULY AUTHORIZED BY OR IN BEHALF OF THE PATIENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS.

Responsible Patient/Party/Insured: ____

Responsible Patient/Party/Insured: ____

Witness: ____

Date and Time: ____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This form serves as an acknowledgement that you have received a copy of Witte Physical Therapy's Notice of Privacy Practices.

Please fill out the lines below and return to the front desk.

Signature: ____

Printed Name: ____

Date: ____

Witte PHYSICAL THERAPY

How Did You Hear About Us?

School Ad

Word of Mouth: (from) ____

Yellow Pages

Social Media: Facebook Twitter

Internet: Google Bing Yelp Community Websites

Website

Cassgram

Plattsmouth Journal

Physician: (from)____

Other Publications or Areas: ____