



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 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 me 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 provided a cellular phone number, I consent and agree to accept collection calls and other communications to my cellular phone from this office and from any 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:



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:[illegible]



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).

2. 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.

3. INSURANCE PRE-CERTIFICATION INFORMATION

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

4. 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 all needed information related to my condition. Finally, if further care from another therapist, physician, or specialist were needed I would 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 ON BEHALF OF THE PATIENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS.

Responsible Patient/Party/Insured: _____

Responsible Patient/Party/Insured: _____

Witness: _____

Date and Time: _____



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: _____



FINANCIAL POLICY

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 co-pays, deductibles, co-insurance, and balances. I understand and agree that I am ultimately responsible for any unpaid balances.

Your insurance is a contract between you and your insurance company. We are not a party to the contract. Not all services are a covered benefit in all insurance contracts. Some insurance companies arbitrarily select certain services they will not cover. These services, if there are any, are your responsibility.

Non-managed Medicare patients are responsible for the co-insurance unless being covered by a secondary or supplemental insurance policy.

If the injury is work-related, a claim number is required before treatment begins. If a claim number is not received or if your case is denied by your worker's compensation insurance, then you are responsible for each additional visit. We require you to provide us with your personal insurance information at your first visit due to these possible work-related issues.

For liability cases, where another party is responsible, you need to provide us with all the billing information. This could include a motor vehicle insurance policy number and contact information, an attorney name and contact information, etc. We require you to provide us with your personal insurance information at your first visit due to these liability case issues.

It is the patient's responsibility to know the benefits and requirements of their insurance carrier as it relates to physical therapy services. We will do our best to verify your benefits and requirements, but as your insurance company states, "nothing is a guarantee of benefits until a claim is received and processed", thus what we verify is not considered 100% accurate until your insurance company has processed a physical therapy claim.

I consent to allowing Witte Physical Therapy to securely store my necessary credit card information for future patient responsible payments.

Due to the rising cost of administrative fees by our software providers, insurance carriers, credit card processors, etc, we have a 3% credit card processing fee to help cover some of these expenses. If you chose to pay by cash, check, or HSA/FSA card this processing fee will not apply.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE FOREGOING, AND IS THE PATIENT, OR IS DULY AUTHORIZED BY OR ON 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

1. 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.

2. 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 using 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 ON 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 FOR MEDICAL PHOTOGRAPHY

I consent for medical imaging (phone, video, and/or 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 ON BEHALF OF THE PATIENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS.

Responsible Patient/Party/Insured: _____

Responsible Patient/Party/Insured: _____

Witness: _____

Date and Time: _____



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

Physician: (from) _____

Other Publications or Areas: _____