GEORGE ERB
PHYSICAL THERAPY INC.

DATE: _____

MINOR PATIENT INFORMATION

Patient Name: _____ □ Male □ Female
First Middle Last

Home Address: _____ City: _____ State: ____ Zip: _____

Home phone: _____ Cell: _____ Date of Birth: _____

Emergency Contact: _____ Phone:_____

Relationship to Patient: ☐ Parent ☐ Guardian ☐ Other _____

Referring Physician: _____ Phone:_____

Address: _____City: _____ State: _____ Zip: _____

MOTHER'S INFORMATION

Name: _____ Date of Birth: _____

Home Phone: _____ Cell: _____ Email: _____

Social Sec. #: _____ Drivers Lic. # _____

Address if different than above: _____

FATHER'S INFORMATION

Name: _____ Date of Birth: _____

Home Phone: _____ Cell: _____ Email: _____

Social Sec. #: _____ Drivers Lic. # _____

Address if different than above: _____

REASON FOR TODAYS VISIT

Is this injury / condition related to your…..

Job: □ Yes □ No **Car:** □ Yes □ No **Home:** □ Yes □ No **Other:** □ Yes □ No

Please indicate the date of accident of injury ____/____/____

Has there been a claim filed? □ Yes □ No Date of illness (first symptom)____/____/_____

Do you have an attorney involved with this accident / injury? **YES** **NO**

If yes, attorney's name: _____ Phone #: _____

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INSURANCE INFORMATION

Primary Insurance Company: _____ Phone: _____

Policy #: _____ Group #:_____

Address: _____ City: _____State: _____ Zip: _____

Name of Policy Holder (if different than patient): _____

Relationship to Patient: ☐ Parent ☐ Guardian ☐ Spouse

Date of Birth (of policy holder): _____ SSN. #:_____

Secondary Insurance Company: _____ Phone: _____

Policy #: _____ Group #:_____

Address: _____ City: _____State: _____ Zip: _____

Name of Policy Holder (if different than patient): _____

Relationship to Patient: ☐ Parent ☐ Guardian ☐ Spouse

Date of Birth (of policy holder): _____ SSN. #:_____

TREATMENT AUTHORIZATION

I hereby consent to and authorize all therapy treatments, which in conjunction with the judgments of the attending physician may be considered necessary or advisable for the diagnosis or treatment of the above named patient at George Erb Physical Therapy, Inc. I understand that I may experience some pain or discomfort during or after treatment. ***PLEASE INITIAL***_____

I hereby give authorization for payment of insurance benefits to be made directly to George Erb Physical Therapy, Inc for services rendered. I understand that I am financially responsible for all charges not paid by my insurance company. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize this health care provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of the agreement is as valid as the original.

_____

Parent / Guardian Signature Relation to Patient Date

****Please note Parent / Guardian signing paperwork becomes the Responsible Party*

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Payment Information and Appointment Policy

Welcome to George Erb Physical Therapy! We would like to take this opportunity to review our billing and payment procedures with you. We will happily discuss your proposed care and answer any questions you may have relating to your treatment and insurance coverage before we begin therapy. We ask that you please take your time in reading our billing policies below.

PRIVATE INSURANCE

George Erb Physical Therapy, Inc. will bill your insurance company for you for all your care one time only as a courtesy to you. You agree to give authorization of insurance benefits to be made directly to George Erb Physical Therapy, Inc for services rendered. You agree to pay any portion of your bill not paid by your insurance company. You agree to be responsible for all your charges, even if you have insurance. All insurance co-payments are due at the time of your visit.

You are responsible to notify us immediately should any changes be made to your health insurance plan. Should you fail to do so, you agree to be responsible for all our charges that are not covered by your insurance.

George Erb Physical Therapy, Inc. mails patient statements at the beginning of every month. If there is any unpaid balance on your account, you will receive a patient statement. Payment is due upon receipt of your statement. If payment is not received by the following month, you will receive a second notice statement, and then a final Notice statement. If we do not receive a payment within 10 days of a Final Notice statement, your account will be sent directly to our collection agency without further notice. In the event of default, you agree to pay all costs of collection and reasonable attorney's fees.

WORKERS COMPENSATION

We will obtain authorization to treat you from your employer's insurance carrier before we begin treatment. You are responsible for making and keeping your own appointments. Carriers will be notified of missed appointments. If you fail to make or keep scheduled appointments, your treatment will be discontinued.

THIRD PARTY BILLING, LIENS AND LEGAL CASES

Third Party billing, and Liens are not accepted at George Erb Physical Therapy, Inc. Payment for services must be made at the time of service and it is the patient's responsibility to get reimbursed from the Third-Party Payer. If we bill your private or Medicare insurance for services related to an injury claim, and your private or Medicare insurance denies or requests a refund, you are responsible for the balance immediately.

MEDICARE

George Erb Physical Therapy, Inc. has been approved as an official certified Medicare Facility. This means that we will bill Medicare for you, we agree to Medicare's rates, and Medicare will send your benefits directly to us. You agree to be responsible for any deductible, co-payment or other charges or items or services denied by Medicare.

Medicare requires you to obtain a new prescription for your treatment every 90 days. We will not be able to continue treatment until a current/updated prescription has been received.

APPOINTMENT / NO SHOW POLICY

We are happy to allow you to schedule your treatment time in advance if you wish. If you find that you are unable to keep an appointment, **please notify us at least 24 hours in advance**. **Late arrival of more than 10-15 minutes may result in shortened treatment or cancellation.** We reserve the right to bill you if you fail to keep a pre-scheduled appointment, or if you cancel less than 24 hours notice, except in cases of true emergency or illness. **Our customary fee of $50.00 will be charged to your account for broken pre-scheduled appointments. This charge will not be billed to your insurance company. You agree that these charges will be solely your responsibility. No Show fees must be paid before your next scheduled**. Patient Initials: _____

I have read, understand, and agree to the above payment procedures and policies of this contract.

_____

Patient Signature (*Parent / Guardian if patient is a minor*) Date

Please Print Name: _____ DOB: _____

Revised 6/12/19

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History and Physical Condition Information

Date: _____

Please answer all questions to help your therapist to provider safe and effective treatment.

Age: _____**Occupation**: _____

Please indicate for which body region you are seeking treatment:

___Neck ___Low Back ___Hand/Wrist ___Knee ___Ankle/foot
___Shoulder ___Mid Back ___Elbow ___Hip ___Other

Date of Injury: _____/_____/_____

Have you recently had surgery for this problem? □ Yes □ No **Date of Surgery?** _____/_____/_____

**If yes, please indicate type of surgery:* _____

Have you had treatment for this problem before? □ Yes □ No **If yes, please list approximate dates below*

_____

_____

Do you now have, or have you ever had any of the following?

High Blood Pressure	□ Yes	□ No	Sensitive to heat / Ice	□ Yes	□ No	Osteoporosis	□ Yes	□ No
Heart Disease or Attack	□ Yes	□ No	Allergies	□ Yes	□ No	Bowel/Bladder		
Hearing Problems	□ Yes	□ No	Hernia	□ Yes	□ No	Changes	□ Yes	□ No
Pacemaker	□ Yes	□ No	Seizures	□ Yes	□ No	Recent Weight		
Diabetes	□ Yes	□ No	Metal Implants	□ Yes	□ No	change	□ Yes	□ No
Headaches	□ Yes	□ No	Dizzy Spells	□ Yes	□ No	Pregnant	□ Yes	□ No
Kidney Problems	□ Yes	□ No	Balance Problems	□ Yes	□ No	Other _____		
Nervous Disorders	□ Yes	□ No	Vision Problems	□ Yes	□ No	_____		
Arthritis	□ Yes	□ No	Cancer	□ Yes	□ No	_____		
						_____		

If your answer is YES to any of the above, please explain and give approximate dates: _____

_____

Job Description/ Social Activities: (physical tasks, amount of sitting, lifting, computer work etc.):_____

_____

_____

_____

What are your goals for your course of physical therapy? _____

_____

_____

_____

List any other major illness or surgery during the past year

_____

_____

_____

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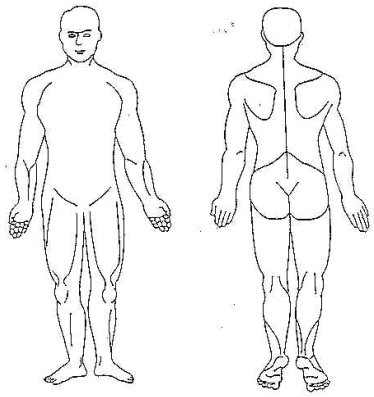
Pain rating: Indicate your average level of pain by circling the appropriate number on the scale below:

0 1 2 3 4 5 6 7 8 9 10

Pain Free *Unconscious Pain*



Please use the body diagram above and *Shade Areas of Pain*

Medication Record

Please list all current medications, with dosages (include prescription, over-the-counter, herbals, vitamins/mineral/dietary [nutritional] supplements).

If you already have a list (including dosages amounts) please check here and provide a copy of the list.
_____ (***Patient initials)***

Medication	**Dosage**	**Reason for Taking**

The above information is correct to the best of my knowledge.

_____ _____
Patient Signature Date

☐ George A. Erb, PT	Lic # PT14408	☐ Megan Henriod, PT	Lic # PT42667	☐ Ryan Woods, PT	Lic # PT298106
☐ Matthew Stump, PT	Lic # PT27127	☐ Collin McDonell, PT	Lic # PT43330		
☐ Jennifer Nichwander, PT	Lic # PT30055	☐ Darren Zaylor, PT	Lic # PT41788		
☐ Cody Hircock, PT	Lic # PT37928	☐ Kara Everhart, PT	Lic #PT294867		

Physical Therapist Signature: _____

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HIPAA Consent & Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have reviewed the Notice of Privacy Practices and understand that I may have a copy upon request. I further acknowledge that a complete and current copy of this notice is posted in the reception area and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signed: _____ Date: _____

Print Name: _____ Relation to patient: _____

Patient Record of Disclosures

In general, the HIPAA privacy rule gives individuals the right to request a restriction on used and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of their home.

I wish to be contacted in the following manner (check all that apply):

Home Telephone: _____ □ OK to leave a message with details □ Leave a message with call-back number only	**Written Communication:** □ OK to mail written communication to my home address □ OK to mail written communication to my work/office address
Work Telephone: _____ □ OK to leave a message with details □ Leave a message with call-back number only	**I give authorization for GEPT to leave a message in my absence with:** _____ **Indicate relation to patient:** _____ **For matters regarding:** □ my appointment reminders □ my account such as billing and amount due □ my treatment/test results
Cell Phone Number: _____ □ OK to leave a message with details □ Leave a message with call-back number only	

_____ _____

Signature of Patient, Parent or Legal Guardian **Date**

For office use only:

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for Treatment Records, Payment Information and Healthcare Operations may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

(This section below is to be completed by Office Staff only when disclosing records)

Date	Disclosed to Whom Address or Fax	(1)	Description of Disclosure/Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized
(2) Type Key: T = Treatment Records; P = Payment Information; O = Healthcare Operations
(3) Enter how disclosure was made; F = Fax; P = Phone; E = Email; M = Mail; O = Other