La Plata Physical Therapy Inc.

Patient Intake Form

PATIENT INFORMATION

Last Name_____ First Name_____ MI_____
Date of Birth_____ Gender □ Male □ Female □ Other Marital Status □ Married □ Single
Address_____
City_____ State_____ Zip_____
Phone #_____ □ Cell Phone □ Home Phone
Secondary Phone # _____ □ Cell Phone □ Home Phone □ Work Phone
Email Address_____

EMERGENCY CONTACT

Last Name_____ First Name_____
Relationship_____ Phone #_____

EMPLOYER

Name/Company Name _____
Address_____
City_____ State_____ Zip_____
Phone #_____

PROBLEM

Description of Problem_____
Date of Injury/Onset Date of Problem_____
Referred By_____ Primary Care Physician_____
Motor Vehicle Accident □ YES □ NO Workers Compensation □ YES □ NO

PRIMARY INSURANCE

Insurance_____
Member ID_____ Group # _____
Subscriber: Name_____ Date of Birth _____
Co-Pay_____ Co-Insurance_____ Deductible _____ Max Out of Pocket_____

SECONDARY INSURANCE

Insurance_____
Member ID_____ Group # _____
Subscriber: Name_____ Date of Birth _____
Co-Pay_____ Co-Insurance_____ Deductible _____ Max Out of Pocket_____

TERTIARYARY INSURANCE

Insurance_____
Member ID_____ Group # _____
Subscriber: Name_____ Date of Birth _____
Co-Pay_____ Co-Insurance_____ Deductible _____ Max Out of Pocket_____

I authorize release of information requested
I understand that I am financially responsible for any balance due.
I agree to comply with the terms and conditions as outlined on the Patient Registration form.
I understand that I will be charged $50 for all no-shows/cancellations w/out 24hour notice.
I herby acknowledge that I have read and reviewed a copy of the Notice of Privacy Practices and the clinics Medical Authorization form.

Signature:_____ Date:_____

La Plata Physical Therapy & Wellness

101 Centennial Street, Suite C
La Plata, MD 20646
301.392.3700 ● FAX 301.392.3876

ACKNOWLEDGMENT OF RISK AND WAIVER OF LIABLITY

We at La Plata Physical Therapy are doing everything we can to assure the health and safety of our patients and employees during the COVID-19 crisis. We are constantly checking for updates with the Center of Disease Control.

The World Health Organization has declared the coronavirus outbreak a global pandemic. Our government is highly suggesting that we practice "Social Distancing" in order to reduce the spread of the virus. Due to this suggestion, we are requiring all patients that choose to continue with therapy in our clinic agree to the following acknowledgment:

With full knowledge of the facts and circumstances surrounding the COVID-19 virus, I voluntarily participate in my physical therapy treatment in the open floor practice and assume the responsibilities and risks resulting from my participation.

_____ _____

Patient Signature **Date**

PRESCRIPTION & NON-PRESCRIPTION MEDICATION FORM

NAME _____

NAME OF MEDICATION	HOW MUCH DO I TAKE	HOW OFTEN DO I TAKE IT	WHAT DO I USE IT FOR

La Plata Physical Therapy & Wellness, Inc.

AUTHORIZATION TO RELEASE INFORMATION TO FAMILY MEMBER

Many of our patients allow family members (ie: spouse, parent(s), guardian(s), children or others) to call and discuss medical information such as appointments, medical records and bills. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have any of your medical information released to family members, please complete the form below.

This is NOT a required form. You have the right to remove this authorization at any time by so requesting in writing.

I, _____, date of birth _____,

Authorize representatives of La Plata Physical Therapy & Wellness, Inc. to share and/or release information to:

1) _____ Relationship _____
(check all that apply)

___ Appointment Information ___ Bills ___ Medical records ___ Any/All Information

2) _____ Relationship _____
(check all that apply)

___ Appointment Information ___ Bills ___ Medical records ___ Any/All Information

3) _____ Relationship _____
(check all that apply)

___ Appointment Information ___ Bills ___ Medical records ___ Any/All Information

I understand that I have the right to change this authorization, at any time, by sending a written notification to this office.

_____ _____

(Signature) **(Date)**

Notice of Privacy Practices and Medical Authorization

1. I authorize the release of medical information required in the processing of applications for financial coverage for services rendered while under the care of La Plata Physical Therapy.

2. I authorize direct payment of medical benefits on my behalf to La Plata Physical Therapy. I understand that I am personally responsible for charges not covered by this assignment at the time of treatment, such as copay and deductible charges. This assignment shall be in affect while under the care of La Plata Physical Therapy.

3. Copays and payments are due at the time of service.

4. If your insurance is a plan with a coinsurance, we will collect payment as follows:

5% - 10% coinsurance	$15.00 payment each visit
15% - 20%	$20.00 payment each visit
25% - 30%	$25.00 payment each visit
40% or more	$30.00 payment each visit

5. I understand that it is my responsibility to present a written referral from my primary care doctor if required. If my insurance company denies my claim because I did not bring in a referral from my PCP, I accept full responsibility of paying the charges in which occurred.

6. La Plata Physical Therapy does not accept payment through any attorney

7. La Plata Physical Therapy accepts auto accident cases of any kind on a SELF-PAY BASIS ONLY. Charges are: $150.00 for Initial Evaluation, $75.00 for each visit after. Payment is due at time of treatment and CAN NOT be billed. The patient will be required to submit receipts to auto insurance for reimbursement.

8. I understand there is a $25.00 charge for ANY appointments that are cancelled or broken without a 24 hour notice. This INCLUDES rescheduling of appointments if 24 hour notice has not been given. No exceptions will be made to this policy. **If multiple no shows, we reserve the right to discharge your case without notice.**

9. I understand that I am responsible for any collection fees incurred if my account becomes delinquent and authorize La Plata Physical Therapy to contact me via phone numbers provided for any billing or financial matters.

_____ _____

Signature **Date**

How did you hear about us?

Friend/Family Referral	Your Health Magazine	Yellow Pages
Pulse Magazine	Drive-by/Walk-by	Previous Patient
Internet Search	Doctor Referral	Charles Regional Ad

Other_____