

# MRPT Physical Therapy, LLC

## Patient Information Form (Please fill in form completely)

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_ Apt #: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone numbers: Home \_\_\_\_\_ Work: \_\_\_\_\_

Cell: \_\_\_\_\_ E Mail: \_\_\_\_\_

Emergency Contact: Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Primary Insurance:**  United  Cigna  Medicare  Aetna  Oxford  
 Healthnet  PHCS  Cash (No Ins)  Other \_\_\_\_\_

**Type of Plan:**  PPO  POS  HMO Please present your insurance card to us

**Reason for Visit:**  Gradual Problem  Sports Injury  Post Surgical  
 Auto Accident  Employment accident  Date of Accident \_\_\_\_\_

## Referral Information:

Referring Physician name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Family Doctor (PCP) name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## Case Profile and History

Have you been treated by a Physical/Occupational Therapist this year?  Yes Number of Visits \_\_\_\_\_  No

Physical/Occupational Therapist name: \_\_\_\_\_ Phone: \_\_\_\_\_

Are you **currently** being treated by a Chiropractor?  Yes  No Date of Last Visit: \_\_\_\_\_

Do you have (or had) any medical conditions that we should be aware of? \_\_\_\_\_

**Making Appointments:** all physical therapy treatments are by appointment only. If you need to cancel a scheduled appointment call us 24 hours in advance. **If appointments are broken less than 24 hours in advance you will be charged a fee of \$75 for the first cancellation and \$150 for subsequent cancellations.**

- **Please be on time for your appointments:** if you are late we reserve the right to either, shorten your treatment time or, cancel your appointment and charge you the \$75 or \$150 cancellation fee.
- **We strongly recommend that you schedule as many appointments in advance as possible.** Mornings, lunchtimes and evenings are very popular appointment times and are booked on a first come, first served basis.

## Patient Responsibility

Taking of the history and conducting a physical examination are an integral part of your treatment and are part of the process of information gathering to determine future care. I understand and agree that health and accident policies are an agreement between an insurance carrier and myself. Furthermore, I understand that MRPT Physical Therapy, LLC will prepare any necessary reports and forms to assist me in making collection from my insurance company. **I understand that verification of insurance benefits are not a guarantee of payment and that my insurance company may deny claims if not deemed "medically necessary".** I authorize my insurance company to assign any insurance benefits for my Physical/Occupational Therapy treatments directly to MRPT Physical Therapy, LLC.

**I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment including any co-payment or co-insurance.** If I suspend or terminate my care and treatment, all patient balance, after insurance payment will be due immediately. If I choose to ignore my responsibility I agree to be liable for all collection and attorney fees if deemed necessary.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Please Turn over**

# MRPT Physical Therapy, LLC

## HIPPA COMPLIANCE AUTHORIZATION FOR DISCLOSURE AND USE OF MEDICAL RECORDS

- **I HEREBY AUTHORIZE** my Primary Care Physician or other specialist to release to **MRPT Physical Therapy, LLC** medical information such as

LAB REPORTS, X-RAY REPORTS, MRI REPORTS and all related medical information as appropriate to assist with the diagnosis and your physical/occupational therapy treatment at **MRPT Physical Therapy, LLC**.

- **I HEREBY AUTHORIZE MRPT Physical Therapy, LLC** to disclose my medical records to my insurance company for the purpose of assisting with the settlement of my insurance claims for Physical/Occupational Therapy.

I UNDERSTAND THAT THIS AUTHORIZATION SHALL BE VALID UNTIL I REVOKE THE AGREEMENT THROUGH WRITTEN NOTICE TO MRPT PHYSICAL THERAPY, LLC

**Name:** ..... **Signature:**.....

**Date:**.....

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### HIPAA Privacy Statement

Our practice is committed to maintaining the privacy of your protected health information (PHI), while providing high quality medical care. In accordance with the HIPAA regulations this notice explains:

- How we may use and disclose your PHI.
- Your privacy rights regarding your PHI.
- Our obligations concerning the use and disclosure of your PHI.

We may use and disclose your PHI for treatment, payment, and health care operations (TPO).

You have the right to inspect, copy, and amend your PHI. You have the right to request restrictions on the use of your PHI. You have the right to an accounting of the disclosures of our PHI for other than TPO.

You have the right to complain about alleged violation to this practice's privacy officer and the U.S. Department of Health and Human Services.

If you have questions, please feel free to meet with our privacy officer for clarification or assistance.