Hereford Physical Therapy & Sports Medicine, Inc

Name :	Date:	Age:
Physician:	Diagnosis:	
Occupation/Activity/Sports:		

E-Mail: _____ Phone: _____

Emergency Contact:_____ Relationship: _____

Phone Number: _____

Date of onset / injury / surgery

How did you injure yourself? (Circle)

Fall Overuse At Work Sports Unknown

Explain

Have you had this injury before? (Circle) Y N

Please explain any previous treatment you have had for this injury _____

Have you had any x-rays, CAT scans, MRIs, or other diagnostic tests for your recent disorder? (Circle) Y N

If yes, please explain the findings as you understand them _____

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

Diabetes	Anxiety/Depression	Bone Disease
High Blood Pressure	Arthritis	Osteoporosis
Heart Condition	Hernia	Fractures
Pacemaker	Dizziness	Bowel/Bladder issues
Chronic Headaches	Seizures	Cancer
Kidney Problems	Pregnant	Previous Surgeries
High Cholesterol		

If you circled any of the above items, please explain _____

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Are you taking any medications -Including over the counter medicines, vitamins or herbal remedies? (Circle) Y N

If yes, please list :

Do you have any allergies? (Circle) Y N

If yes, please list :

Do you have pain? Y N

If so, in what area is your pain?

Pain Level on scale 0 - 10 No Pain 0 1 2 3 4 5 6 7 8 9 10 Emergency Room Pain

At best _____ At Worst _____ Average _____

Nature of Pain Sharp Shooting Dull achey Burning Numbness Tingling

Frequency Constant Occasional Intermittent

What activities are the most difficult for you at this time?

_____

What is your goal for Physical Therapy?

_____

Right now, I feel I am getting (circle):

Better Worse Staying the same

Patient Signature:	Date:

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Patient Acknowledgement Form

Use & Disclosure of Protected Health Information

- Hereford Physical Therapy and Sports Medicine's "Notice of Privacy Practices" provides information about how we may use and disclose protected health information about you. This information is also available and may be downloaded at our website www.herefordpt.com. Please acknowledge receipt of this office's Notice of Privacy Practices by initialing below.

- Our Notice of Privacy Practices states that we reserve the right to change the terms described. Should this happen, you will receive a revised copy by mail (or explain your discretionary terms).

- You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree to your restrictions, but if we do, we are bound by our agreement with you.

- By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to evoke this consent, in writing, except where we have already made disclosures in trust on your prior consent.

_____ _____

Signature Date

Hereford Physical Therapy & Sports Medicine, Inc

Financial Payment Policy

Thank you for choosing Hereford Physical Therapy and Sports Medicine as your physical therapy provider. We are committed to providing you with the best possible treatment. Please understand that payment of your bill is considered a part of your care.

Regarding Insurance

If you have insurance coverage with one of the insurance plans we participate with, we will bill your insurance company along the guidelines of our contract. As a courtesy to our patients, we will submit all claims directly to the appropriate insurance party. However, we require that **ALL CO-PAYS or CO-INSURANCES** be paid at the time of service. Please be aware that some, and perhaps all of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/ or other medical insurance programs. Understand that your selection of insurance coverage is a contract between you and the insurance company. We are not a party to that contract.

If you have an insurance with which we do not participate, we ask that payment be made at the time services are rendered. This may also apply to any auto accident and/or third party injury claim. As a courtesy we will provide the necessary forms to submit your claim independently to your insurance provider or third party representative.

High Deductible Insurance Plans / Health Savings Accounts

Many patients now have high deductible insurance plans and/or Health Saving Accounts. These plans typically have $1200 to $2400 insurance deductibles. **All healthcare costs incurred are the patient's responsibility until the deductibles are met.** After the deductibles are reached, your insurance company will begin payment to the provider. Please be aware, in many instances you will still be responsible for a co-payment or co-insurance per visit. Hereford Physical Therapy will continue to bill your insurance company as a courtesy. Once we receive an explanation of benefits (EOB) from your insurance company, we will provide you with an itemized statement and require payment.

Regarding Payment

Payment is due at the time of service. At this time, we accept Cash, Check, Visa, MasterCard, Discover and Health Savings Account cards. Returned checks will be subject to an additional $25.00 service fee.

Missed Appointments

We ask all patients to please call our office to cancel appointments they are unable to keep so we may schedule other patients that may need physical therapy that day. If you are unable to keep an appointment and fail to call our office, you will be billed a $25.00 service fee for those missed appointments.

Proof of Insurance

You will be required to show an up to date copy of your insurance card and any necessary referrals at the time of service. If you do not have this information, or we are unable to verify your coverage, you will be required to pay for the services rendered to you that day.

I hereby understand the financial policy of this office. I guarantee payment of all charges incurred for the account of the below patient. I further agree to pay any attorney's fee, court costs, and related collection fees incurred.

Patient Name Responsible Party Signature Date