Therapy Services, LLC
PATIENT INFORMATION FORM

Date: _____ Medical record number: ___-___-___ Case number (Waiver):_____

Patient's full name: _____ Social security number: _____

Street address: _____ Phone number: _____

City, State, Zip: _____ Date of birth: _____ Sex: F____ M ____

Patient status (circle all that apply): Single Married Employed Part-Time Student Full-Time Student

RESPONSIBLE PARTY

Full name: _____ Home phone number: _____

Street address: _____ Work phone number: _____

City, State, Zip: _____

Employer name: _____

Employer address: _____

Patient's parent/guardian name (if minor): _____

Patient relationship to insured (circle one): Self Spouse Child Other

INSURANCE

Primary Insurance_____ Phone number _____

Address _____ Policy number _____

Name of insured _____DOB:__/__/____ Group number _____

Social security number of insured _____Sex: ___M ___F__ Work number_____

Insured's employer _____

Employer address _____

Secondary Insurance_____ Phone number _____

Address _____ Policy number _____

Name of insured_____ Group number _____

Waiver agency information: _____

CONSENT FOR OCCUPATIONAL, PHYSICAL AND/OR SPEECH THERAPY

I am entering Therapy Services, LLC voluntarily for the purpose of occupational, physical and/or speech therapy and do hereby consent to such treatment. I am responsible for paying for services provided to me, which may include collection fees. I authorize Therapy Services, LLC to release my medical records to any person or company who may need them for my continuing care, for payer review of medical services provided (utilization review) and/or for payment of my account.

_____ _____

Signature of insured/guardian Date

ASSIGNMENT AND RELEASE, GUARNATEE OF ACCOUNT

I hereby authorize and assign payment directly to Therapy Services, LLC for any medical benefits otherwise payable to me. I hereby authorize Therapy Services to release all information necessary to secure the Payment of benefits. I authorize the use or this signature on all insurance submissions. I understand that I am financially responsible for all charges whether or not paid by insurance. I accept responsibility for payment of the deductible, co-payment and non-covered services.

_____ _____

Signature of insured/guardian Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made to Therapy Services LLC for any services and/or equipment furnished to me. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA- 1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Signature of insured/guardian Date

MY SIGNATURE INDICATES THAT I HAVE READ AND UNDERSTAND THE POLICY OF THIS OFFICE

Therapy Services does not have any agreements with any insurance companies to settle claims for patients. Our agreement is SOLELY with our patient. We will submit your insurance for you.

Revised 7-20-2009 HIPAA Compliant

Therapy Services LLC

Name: _____ Medical record number: _____

Patient's school: _____

Physician: _____ Phone number: _____

Physician address: _____

Referred by: _____

Reason for referral: _____

Type of Assessment: Speech Therapy Occupational Therapy Physical Therapy Augmentative Communication

Statement of problem: (Describe briefly what the reasons are for the referral to this facility):

_____

_____

Is Patient's condition related to:

Employment current or previous (circle one):	**Yes**	**No**	If yes, dates unable to work_____
Auto accident (circle one)	**Yes**	**No**	If yes, State where accident occurred_____
Other accident (circle one)	**Yes**	**No**	

Hospitalization dates related to current services: _____

Physical/Medical information:

DATE OF ONSET: Injury/Problem/Surgery:_____

Briefly state previous treatment, if any:_____

_____

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

DIABETES	YES___NO___	ALLERGIES	YES___NO___
HIGH BLOOD PRESSURE	YES___NO___	PREVIOUS SURGERY	YES___NO___
PACEMAKER	YES___NO___	SIEZURES	YES___NO___
CHRONIC HEADACHES	YES___NO___	METAL IMPLANTS	YES___NO___
KIDNEY PROBLEMS	YES___NO___	DIZZINESS	YES___NO___
NERVOUS DISORDERS	YES___NO___	CANCER	YES___NO___
HERNIA	YES___NO___	PREGNANT	YES___NO___
BONE DISEASE	YES___NO___	OSTEOPOROSIS	YES___NO___
FRACTURES	YES___NO___	BOWEL PROBLEMS	YES___NO___
BLADDER PROBLEMS	YES___NO___	RECENT WEIGHT LOSS	YES___NO___
PINS & NEEDLES	YES___NO___	CIRCULATORY DISEASE	YES___NO___
PROBLEMS WITH BOTH ARMS OR LEGS AT THE SAME TIME			YES___NO___

If YES to any of the above, please explain and give appropriate details:_____

_____

_____

Are you presently taking any medications? YES___NO___

If YES, please list your medications and for what condition:_____

_____

_____

Have you had any x-rays, CAT scans, MRIs, or other diagnostic tests for your recent disorder?
YES___NO___ If YES, please explain the findings as you understand them _____
_____
_____

Is there anything else you think I should know about your general health, or current condition? Please explain and, if necessary, we can talk about it: _____
_____
_____

Allergies (Please List):_____
_____

Patient/Family Goal: _____
_____
_____

Patients are forbidden from possession, consumption, or being under the influence of any type of non-prescribed controlled substance or alcohol while attending therapy. If a patient abuses this policy, the patient will be discharged from therapy.

I agree to abide by the above policy regarding alcohol and drug abuse.

_____ _____

Patient/Guardian Signature Date

****

EMERGENCY CONTACT _____RELATIONSHIP_____

PHONE # _____

ALTERNATE CONTACT _____RELATIONSHIP_____

PHONE # _____