Legacy Physical Therapy
Registration Information

Patient Information (Please Print)							
Patient's Name:							
Responsible Party (if a minor)		Relationship to Patient					
Address							
City		State		Zip			
Home Phone #		Cell Phone #					
Email							
Are you interested in receiving important health related information via e-mail?		Yes		No			
Sex	□ M □ F	Age		DOB			

Emergency Information			
Name of emergency contact			
Phone #		Relation	

History				
Is your current complaint related to an auto accident?	Yes		No	
Is your current complaint related to a worksite injury?	Yes		No	

What medications are you currently taking?

How many hours of sleep do you average per night?				
Do you participate in any sport or regular exercise/activity?	Yes		No	
If yes, what do you do?				

How did you hear about us?

□ Medical Doctor □ Family □ Friend □ Ins. Company □ Driving by □ List from MD □ Newspaper Ad □ Phone Book

□ Other : _____

Legacy Physical Therapy
Patient History

Name: _____ Date: _____

Do you have a history of high blood pressure? Yes_____ No_____

Do you have a history of heart problems? Yes_____ No_____

Do you have a pacemaker implant? Yes_____ No_____

Do you have any metal implants (pins, plates, screws, IUD)? Yes_____ No_____

Do you have any sensory impairment? Yes_____ No_____

Are you pregnant? Yes_____ No_____

Do you have any history of diabetes? Yes_____ No_____

Do you have any history of cancer? Yes_____ No_____

Do you have any history of circulatory problems? Yes_____ No_____

Do you have any history of seizures? Yes_____ No_____

Do you have any history of broken bones? Yes_____ No_____

Do you have any history of any type of hepatitis? Yes_____ No_____

Any recent changes in bowel or bladder function? Yes_____ No_____

Have you had any unintended weight loss recently? Yes_____ No_____

If yes, how many pounds in the last 3 months? _____

Please list any past surgeries:

_____
_____
_____
_____

Have you ever had physical therapy before? Yes_____ No_____

If yes, was it for the same condition as today's visit? Yes_____ No_____

Legacy Physical Therapy
Patient-Specific Functional Scale

Name: _____ Date: _____

Please read the following and complete.

Please identify **up to three important activities** that you are unable to do or are **having difficulty with** as a result of your current problem/diagnosis (i.e. the reason your doctor has referred you to therapy). Today, are there any activities that you are unable to do or having difficulty with because of your problem/diagnosis? Please rate each of these problems on the 0-10 scale below.

0 = Able to perform activity at the same level as before injury or problem (No issues)

10 = Unable to perform activity (Cannot perform)

Patient-specific activity scoring scheme (Circle one number or provide a range):

Activity	**Score**
	0 1 2 3 4 5 6 7 8 9 10
	0 1 2 3 4 5 6 7 8 9 10
	0 1 2 3 4 5 6 7 8 9 10

Total score: _____

Legacy Physical Therapy
Health Insurance Portability and Accountability Act Statement

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used in the below circumstances.

I understand and give authorization to Legacy Physical Therapy to make telephone calls to my home about my health related information and appointment reminders. A message may be left on my answering machine/voice mail.

I understand that a letter may be sent to my primary physician and other healthcare providers (i.e. chiropractor, dentist, massage therapist, OBGYN, surgeon, acupuncturist, other medical specialist) that I see for medical care informing him/her that I am currently having therapy. If he/she requests updates on my progress, I am giving authorization to Legacy Physical Therapy to send him/her copies of my progress reports that are also being sent to the referring physician. Please list below any EXCEPTIONS for providers that you do not authorize us to contact:

_____

_____

I hereby give my permission for authorized personnel of Legacy Physical Therapy to perform all necessary procedures and treatments outlined in the plan of treatment.

I hereby authorize a representative of Legacy Physical Therapy to be permitted to obtain and review copies of all hospital, medical, vocational, and other related records and to discuss pertinent information with professionals involved in my case.

EXCEPTIONS: (Please list) _____

In specific instances I also authorize Legacy Physical Therapy to share information regarding my rehabilitation to/from my employer. I understand that the information shared will be used to assist in tailoring my rehabilitation program to my specific job tasks. If applicable, name of employer/contact information: _____

This consent is to remain in effect until otherwise revoked by me in writing. I agree that a photocopy of this authorization be accepted if necessary.

I, _____, have read and understand the above as well as the privacy notice provided to me by Legacy Physical Therapy.

Signature: _____ Date: _____

Legacy Physical Therapy
Financial Agreement

We would like to take a moment to welcome you to our office and assure you that you will receive the very best care available for your condition. In order to familiarize you with the financial policy of this office, we would like to explain how your medical bills will be handled.

Insurance Coverage
Most insurance policies cover physical therapy, but this office makes no representation that yours does. Insurance policies can differ greatly in terms of deductible and percentage of coverage for physical therapy. Because of the variance from one insurance policy to another, we require that you, the patient, are personally responsible for verifying benefits with your insurance company and for payment deductibles, as well as any unpaid balances in this office. We will bill your insurance company(ies) in a timely manner. Your co-payment and/or co-insurance are required prior to each treatment. Any over payments will be refunded to you. An interest charge of 1 ½% per month may be applied to your past due balance.

Assignment of Benefits
Attached is an "Assignment of Benefits" form that we would like you to sign. This form instructs your insurance company to send their payments directly to this office. Please sign all copies of this form. If your insurance carrier sends you payment for services incurred in this office, you shall send or bring the full payment to our office immediately upon receipt.

Rescheduling/Canceling Appointments
If it is necessary for you to re-schedule an appointment, please call at least 24 hours in advance. If you are a no-show twice for an appointment we will charge you a $25 service fee. This would not be covered by insurance and a bill will be sent to you directly. After a third time no-show, you will be billed an additional $25 service fee and discharged back to your referring physician with an explanation.

Voluntary Termination of Care
If you suspend or terminate your care at any time, your portion of all charges for professional services is immediately due and payable to this office. All services rendered by this office are billed to your insurance company and the balances will be charged directly to you, and you ultimately will be personally responsible for payment, regardless of your insurance coverage.

Attention Medicare Patients
We are a certified provider under Medicare Part B. Medicare has placed a financial cap on physical therapy benefits for a limitation of $2040.00 for outpatient physical therapy benefits. Medicare has a deductible of $135.00 and pays 80% of approved services. Please inform us if you have secondary coverage. If you have had physical therapy at another facility this calendar year, please advise us on your first visit.

Previous Patients
If you have received physical therapy from our office at a previous date and have a balance from a previous account, you will be required to pay no less than 50% of the balance and arrange a firm payment plan for the remaining balance prior to initiating a new account.

We hope that this answers any questions you might have concerning the financial policies of this office. Once again, we welcome you to our office and will be glad to answer any further questions you might have.

I have read and agree to the above.

Patient's Signature: _____ Date: _____

Legacy Physical Therapy
Co-Pay and Co-Insurance is Collected at Each Appointment

Co-Insurance is an estimated amount calculated by our billing department according to your insurance benefits.

Patients may receive a monthly bill for additional co-insurance due if we have under-estimated the amount after your insurance begins paying your claims. We will adjust your payment amount if necessary at that time.

This is a Legacy Physical Therapy business policy done to relieve the possible financial burden to our patients of receiving large monthly statements. Your insurance deducts the co-insurance you owe from their payments to Legacy Physical Therapy for your treatment. Since physical therapy is an on-going treatment, these un-paid portions due from patients can add up quickly.

Please understand that this is a service we provide to you. Many facilities do not do this and simply send a large monthly bill for co-insurance due in full in 30 days. We want you to be able to concentrate on your treatment and getting well quickly, not how you will pay your bill.

Thank you for your anticipated cooperation.

I have read the above

Patient Signature: _____

Assignment and Instruction for Direct Payment to Health Provider

Patient: _____

Address: _____

City: _____State: _____ Zip: _____

Insurance Company: _____

Claim or Group #: _____

I hereby instruct the above named Insurance Company to pay directly to:

Legacy Physical Therapy

For professional or medical expense allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment or as required by my insurance policy.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED EFFECTIVE AND VALID AS THE ORIGINAL

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, attorney or state appeal board for the purpose of securing payment under this policy or insurance.

Signature of Policy Holder: _____

Date: _____

Signature of Claimant, if other that Policy Holder: _____