Back To Normal Physical Rehabilitation
New Patient Information Form

==========Patient Information==========

Last Name:_____ First Name:_____ Middle Initial_____

Address Street:_____City_____State:_____ Zip:_____

Home Phone:_____ Cell #:_____ **DOB**_____ SSN_____

Employer: _____ Employer's Phone #:_____ Email _____

****Are you currently receiving Home Health Services:_____** Marital Status: Single Married Divorced Widowed

In case of emergency, contact _____ Phone#_____

==========Insurance Information==========

Policy Holder's relation to the patient: (Circle One) Self Spouse Parent/Guardian Other

Primary Insurance Co:_____ **Name of Insured**:_____

Address of Insured:_____ **DOB:**_____ SSN:_____

Insured's Employer:_____ Employer's Phone #:_____

Secondary Insurance Co:_____ Name of Insured:_____

Address of Insured:_____ DOB:_____ SSN:_____

Insured's Employer:_____ Employer's Phone #:_____

==========Other Information==========

Physician who wrote your prescription:_____Physican Phone #:_____

Diagnosis or Chief Complaint:_____**Date of Injury**/Date pain began: _____

Have you received physical/occupational/ speech/massage therapy during this calendar year? _____ # of visits:_____

If yes, which service and where? _____

==========Personal Injury Cases Only==========

Motor Vehicle Accident: (Circle One) Yes or No Work Related Injury: Yes or No Other: _____

Auto insurance Carrier/Attorney Name:_____ Phone#_____

Contact_____Address:_____

Claim#_____

Are you using med-pay? _____ How much do you have remaining? _____

Is this Worker's Compensation? _____ Insurance Carrier:_____ Claim#:_____

Contact Person:_____ Phone Number: _____

"I acknowledge that the information I have provided is true and correct, and that I am ultimately responsible for payment of all charges incurred for my therapy. I authorize Back To Normal to render treatment to me, understanding that there are possible risks associated with physical therapy treatment. I irrevocably authorize and demand the assignment of my basic medical, major medical, auto medical, third party medical or any other medical benefits that may apply, herein specified and otherwise payable to me, directly to Back To Normal. I have read and understood the statements contained herein."

_____ _____

Signature of Patient or guarantor (if not patient) Date

BACK TO NORMAL PHYSICAL REHABILITATION

PATIENT ADMIT SHEET

Patient Name _____

Date _____

List medications you are currently taking and the reason for taking it.

Meds & Dosage:	Medical Condition:
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____
8. _____	_____

List any surgeries you have had in the past.

_____

_____

_____

_____

_____

_____

BACK TO NORMAL PHYSICAL REHABILITATION

PATIENT RIGHTS

I. Patients have the right to be treated with consideration, respect and full recognition of the patient's dignity and individuality, including privacy in treatment and personal care needs;

II. Patients have the right to be free from chemical, physical and psychological abuse or neglect;

III. Patients have the right to refuse or withdraw consent for treatment or give conditional consent for treatment;

IV. Patients have the right to medical and financial records kept in confidence and the release of such records shall be by written consent of the patient or the patient's representative except as otherwise required or permitted by law;

V. Patients have the right to be informed of the following:

A. Proposed treatment procedures and side-effects involved;

B. Cost of services prior to obtaining services or prior to change in rates, charges, or services

C. Notice of third party coverage, including Medicare and Louisiana Health Care Cost Containment System coverage; and

D. The patient grievance process.

_____ _____

Patient Signature Print Patient's Name

_____ _____

WITNESS DATE

BACK TO NORMAL PHYSICAL REHABILITATION

Financial Responsibility/Assignment of Benefits:

Payment is due at the time of service.

There will be a $30 service charge for any returned payments.

All patients must have a current insurance card on file before receiving services.

Insurance: Please remember it is your responsibility to know your insurance policy. Please be sure to read the policy book given to you by your employer or insurance agent.

All co-payments and/or deductibles are due at the time of service. Our office will file all claims for you with your insurance company using the necessary reimbursement forms. This is done as a courtesy for the patient. We cannot bill your insurance company unless you give us valid proof of insurance. If your coverage changes to a plan in which we do not participate, you will be responsible for payment in full at time of service**. If your insurance changes while you are attending therapy, you are responsible to notify us immediately of the change.**

We will bill your health insurance company and use our best efforts to obtain payment. Any amount that your insurance company has not paid within 90 days from the date of service will become your responsibility. All amounts will be due and payable in full within 30 days from the date you are billed. If for any reason your account should become delinquent, you agree to pay a delinquency charge of 5% of the unpaid amount or $10.00, whichever is greater. Further, should Back To Normal be required to turn this account over to an attorney at law for collection, you agree that you will be liable for Back To Normal's attorney fees in the amount of 25% of the unpaid amount after referral for collection.

If payment is not made in a timely manner, your account may be sent to a collection agency. If this occurs, you will become responsible for any delinquency/ interest fees in addition to the actual amount owed.

I hereby instruct and direct my Insurance Company/ Workers' Comp Co. to pay by check made out and mailed to: Back To Normal Physical Rehabilitation, 4795 Freedom Rd, Houma, LA 70360.
If my current policy prohibits direct payment to provider, I hereby instruct and direct you to make out the check to me and mail it as follows: Back To Normal Physical Rehabilitation, 4795 Freedom Rd, Houma, LA 70360, for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the 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 service charges over and above this insurance payment.

A photocopy or fax transmission of this Assignment shall be considered as effective and valid as the original. I authorize this provider to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Personal Injury Cases: If you have obtained an attorney, a deposit will be collected upfront and payment must be made on a monthly basis until settlement is reached, at which time payment in full is due. If the attorney does not make payments monthly, patient will be responsible for payment at time of service.

I grant permission for my physician to release my medical records to Back To Normal. I hereby authorize Back To Normal Physical Rehabilitation to release any medical information necessary to process any of my insurance claims. This authorization will remain in effect until revoked by me in writing.

I have read and understood the statements contained herein and I agree to the payment policies of Back To Normal.

Patient Signature:_____ Date:_____
(or Guardian)

Print Patient Name:_____

****Please refrain from wearing any cologne, perfume or other scent when attending physical therapy.****

ATTENTION MEDICARE PATIENTS

Medicare **will not** cover outpatient physical therapy services if you are receiving **any** home health services. (This means if anyone is going to your home and performing any medical service for you.)

It is very important that you notify us if you are to begin receiving home health services any time during your course of therapy.

If you do not notify us, **you will** be responsible for any charges that Medicare does not cover.

Your signature below confirms that you understand and will comply with this policy.

_____ _____

Patient Signature Date

_____ _____

Printed Patient Name Office Staff Witness

NOTICE
CANCELLATION/NO SHOW POLICY

We feel that it is important that we provide one-on-one care to our patients from a qualified therapist. The majority of clinics often schedule patient's visits in groups or with physical therapy technicians and do not offer more than about 5 minutes "hands-on" care.

In order for us to continue our quality service, it is essential that 24-hours notice be given so that we can offer this session to someone else in need of therapy.

- A **24-hour** cancellation notice will be required for all scheduled therapy sessions.
- We understand that emergency situations arise occasionally and naturally the fee will be waived. We would appreciate a phone call as soon as possible to reschedule the appointment.
- A charge of **$90** will be incurred for the following:
  - **Failure to show-up for a scheduled appointment.**
  - **Failure to give 24-hour notice prior to canceling an appointment.**
- This fee will have to be paid in cash at your next scheduled appointment. If you will not be returning to therapy, an invoice will be mailed to you for payment. **You** are responsible for this fee; we can't bill anyone else for it.
- If you do not show up for your appointment and we do not hear from you before your next scheduled appointment, we will have to remove you from any future appointments. Please call before returning.

Thank you for your business and your cooperation in this matter.

_____ _____

Patient Signature Date

_____

Office Staff Witness