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 #:_____

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

In case of emergency, contact _____ Phone#_____

Email Address: _____

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 therapy during this calendar year? _____ # of visits:_____

If yes, which service and where? _____

Work Related Injury: Yes or No

Worker's Comp. Company:_____ Claim#:_____

Adjuster's Name:_____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 grant permission for my physician to release my medical records to Back To Normal, and I authorize Back To Normal to release my therapy records/medical information acquired in the course of my evaluation and treatment to my insurance carrier or other parties responsible for the payment of my therapy bill. 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. If for any reason the account should become delinquent, I agree to pay all rebilling charges, collection costs and reasonable legal fees. 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.

_____

_____

_____

_____

_____

_____

Welcome to Back To Normal

Please take a moment to review our payment policies.

Payment Policies:

All charges that you incur at our office are your responsibility. You may pay for your charges at each visit or choose to use our insurance filing service. There is no extra charge to use this service, however you must agree to the following terms:

We will file all insurance claims for you. Your insurance company/worker's compensation company must allow you to have reimbursement payments sent directly to us. If your insurance company/ worker's compensation company does not allow this, we require that you pay for all treatments at the time of each visit.

Authorization must be obtained in advance for all workers' compensation claims. If we are unable to obtain authorization, and you wish to continue with therapy, you will be responsible for the charges incurred.

All returned checks and balances over 90 days may be subjected to additional collection fees.

Your 3rd party payer will not cover the Cancellation/ No show fee; this will be your responsibility.

Financial Responsibility:

We will bill your insurance company/ worker's compensation company and use our best efforts to obtain payment. However, any charges, which remain unpaid for 60 days after billing, become your responsibility to pay. You will receive a statement monthly, which will notify you of any charges that your insurance company declines to pay. It will also inform you of any payments made by your insurance company and you and of your present balance. If your accident results in a litigation process, payment must be made on a monthly basis until settlement is reached, at which time payment in full is due.

I would like to use the insurance filing service of this clinic and agree to the terms listed above.

I have read and understand the payment policies of Back To Normal.

Signature:_____ Date:_____

Patient's Name Printed:_____

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 inform 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

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. From now on we will be enforcing the following cancellation/no show fee. We have been very lenient in the past regarding this fee; however, with an increased patient volume and limited time slots we have no choice but to be strict. Recently, we have had a very high number of patients canceling on the day of their appointment or not showing up at all.

- A **24-hour** cancellation notice will be required for all scheduled therapy sessions.
- We understand that emergency situations arrive 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 at your next scheduled appointment. If you will not be returning to therapy, an invoice will be mailed to you for payment.
- 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