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
PATIENT RESPONSIBILITY FORM/PAYMENT POLICY

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 will be responsible to pay $90 for the initial evaluation then $90 up to ½ hour, per visit. We accept checks, exact cash or Credit/ Debit cards. There will be a $30 fee on all returned payments.

Please initial stating that you understand & agree: _____

All returned checks will be subject to additional collection fees.

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

Signature:_____ Date:_____

Print Patient's Name:_____

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