Wyoming Specialized Physical Therapy

Please provide a copy of your ID and Insurance Card with this paperwork.

Patient Information:

Name: _____ Social Security #: _____

Date of Birth: _____ Age: _____ Sex (Circle): M F Marital Status (Circle): S M D W

Physical Address: _____City: _____ State: _____Zip: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____Cell Phone: _____ Email: _____

Receive Appointment Reminders? (Circle): EMAIL or TEXT (Standard Text Messaging Rates Apply) Cell Carrier: _____

Employer: _____Full time/Part time Work Phone: _____

Responsible party for anyone under 18:_____ Relationship to Patient:_____

Emergency Contact: _____ Emergency Contact Phone Number: _____

Referring Physician: _____

Have you been under Home Health Care in the last month? _____ If yes, please specify_____

How did you learn about this facility? Check all that apply:

□ Physician □ Insurance Company □ Telephone Book □ Newspaper □ Website □ Home Health

□ You are a Former Patient □ Family/Friend (Let us know who we can thank for your business!)_____

□ Other (please specify) _____

Insurance Information:

□ **No Insurance – Bill Me Personally**

□ **Workers Compensation Claim: State: _____ Claim Number: _____**

Case Worker: _____ Case Worker Phone Number: _____

□ **Primary Insurance Information:**

Policy Holders Name: _____ Relationship to patient: _____

Birth date of insured: _____Insured Social Security#_____Employer:_____

Insurance Name: _____ Insurance Phone: _____

Policy #: _____Group Number: _____

□ **Secondary Insurance Information:**

Policy Holders Name: _____ Relationship to patient: _____

Birth date of insured: _____Insured Social Security#_____ Employer: _____

Insurance Name: _____ Insurance Phone: _____

Policy #: _____ Group Number: _____

PATIENT PAYMENT AND INFORMATION AUTHORIZATION AGREEMENT

PLEASE READ CAREFULLY BEFORE SIGNING

1. I give my consent to be evaluated and treated at Wyoming Specialized Physical Therapy, Inc.
2. I understand that a copy of the **Notice of Privacy Practices** is available to me.
3. I understand that I am responsible for my bill.
4. I understand that **copays will be expected at the time of service.**
5. I agree to pay reasonable late fees, attorney fees and any additional fees if my account becomes delinquent and if it becomes necessary to turn my account over to a collection agency.
6. It is the patient's responsibility to provide us with complete and accurate insurance information in order for us to bill. The patient must also provide any other special requirements by the insurance company. The requirements may include but are not limited to, referrals from primary care physician, accident information, or pre-authorization from ordering doctor.
7. I understand that Wyoming Specialized Physical Therapy will bill my insurance company as a courtesy one time. We encourage you to follow up with your insurance company on all of your claims to ensure timely processing and avoid any other delays.

REFERRAL (PRESCRIPTION):
A physician's referral for physical therapy treatment is required by some insurance companies for reimbursement. Physical Therapy services can be rendered without a referral but cash payment will be required if your insurance carrier does not reimburse without a referral.

MEDICARE / WORKERS' COMPENSATION PATIENTS:
Medicare and Workers' Compensation will not pay for a physical therapy visit unless the patient has seen their referring physician within 30 days of that visit. Please let us know when you see your doctor. If Medicare or Workers' Compensation does not pay for your physical therapy because you have not seen the doctor within 30 days of the physical therapy visit, the charges for service will be your responsibility. **If Workers' Compensation claims are not being paid due to objections then patient's private insurance will be billed, or the patient directly.**

SECONDARY INSURANCE BILLING:
We will bill secondary insurance once the primary carrier has responded. If the primary insurance has made payment directly to the patient we must have a copy of the Explanation of Benefits in order to bill the secondary carrier. In the event that the primary carrier has not responded to our claim, we will not take action to collect from the secondary carrier in the patient's behalf.
In the event that industrial or auto insurance exhausts or refuses to pay I authorize Wyoming Specialized Physical Therapy, Inc. to bill my personal health insurance, or the patient directly.

PAYMENT PLAN:
We allow 30 days for patients to pay their patient balance in full. All accounts not paid by 30 days will be assessed a late fee of 25% per month. Accounts not paid in full by 90 days will be assessed a 50% handling fee to the current balance and then turned over to a collection agency. The account balance is the responsibility of the patient or responsible party whether the insurance pays or not.

PATIENTS WITHOUT INSURANCE
If the patient does not have insurance, payment for services rendered will be expected at the time of service.

PATIENTS NAME: _____ DATE OF BIRTH: _____

SIGNATURE OF PATIENT
OR RESPONSIBLE PARTY: _____ DATE: _____

OFFICE REP.: _____ DATE: _____

I guarantee payment of all physical therapy charges for treatment provided to the above named patient to Wyoming Specialized Physical Therapy, Inc. I understand that I am financially responsible for all charges including but not limited to all co-payments, deductibles, and expenses not covered or paid by insurance.

Wyoming Specialized Physical Therapy, Inc.

To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you do not understand a question, leave it blank and your therapist will assist you. Thank you!

Name: _____ Date: _____ Age: _____

Occupation: _____

Is this a Worker's Compensation injury? ____Yes ____ No Date of Injury _____

Is this due to an Automobile Accident? ____Yes ____ No Date of Accident _____

Are you working with a lawyer for this injury/condition? ____Yes ____ No Name of Lawyer _____

When did your current condition begin? Month _____Date_____ Year_____ Surgery Date_____

Are you currently: (Please Check One)
____a. Working at your usual job without restrictions ____ b. Working at your usual job with restrictions
____c. Retired/Unemployed ____ d. Unable to work because of other medical reasons
____e. Unable to work because of your condition

What originally caused your current symptoms? (Please Check One)
____a. Not sure of the cause ____b. Fall/Slip ____c. Motor Vehicle Accident ___d. Bent/twist
____e. Cough/Sneeze ____f. Lifting ____g. Yard Work ____h. Athletic Activity ____i. Shoveling Snow
____j. Other_____

PAIN INTENSITY: At it Best 0-10 _____ At its Worst 0-10 _____ Now 0-10_____
0= No Pain 10= Emergency Room

ALLERGIES: List any medication(s) you are allergic to: _____

Are you latex sensitive? ____Yes ____No

List any other allergies we should know about: _____

Have you declared the Advanced Clinical Directive of Do Not Resuscitate? _____Yes _____No

Please check any of the following whose care you are under:
____Medical Doctor (MD) ____Psychiatrist/psychologist ___Osteopath ____Dentist ____Chiropractor
____Other_____

If you have seen any of the above during the past three months, please describe for what reason (illness, medical condition, physical, etc.:

_____

_____

What is your current height? _____ What is your current weight? _____

Have you EVER been diagnosed as having any of the following conditions?

YES NO Cancer-IF yes describe what kind: _____
YES NO High Blood Pressure
YES NO Asthma
YES NO Chemical Dependency (i.e., alcoholism)
YES NO Diabetes
YES NO Rheumatoid Arthritis
YES NO Other Arthritis Conditions
YES NO HIV/AIDS
YES NO Stroke
YES NO Anemia
YES NO Epilepsy
YES NO Heart Problems
YES NO Circulation Problems
YES NO Emphysema/Bronchitis
YES NO Thyroid Problems
YES NO Multiple Sclerosis
YES NO Depression
YES NO Hepatitis
YES NO Tuberculosis
YES NO Kidney Disease
YES NO Osteoporosis
YES NO Other_____

Have you had: ____X-rays ____MRI ____CT Scan ____Other Diagnosis ____Studies

How many falls have you had in the last year? _____ Did an injury occur with any falls? YES / NO

FOR WOMEN: Are you currently pregnant or think you might be pregnant? _____Yes _____No

Please list any injuries, surgeries, or other conditions you have treated or hospitalized for, including the approximate date, side and reason for the treatment:

DATE **REASON FOR INJURY/SURGERY/HOSPITALIZATION**

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____

Has anyone in your immediate family (parents, brothers, sisters) EVER been treated for any of the following?

YES NO Diabetes
YES NO Tuberculosis
YES NO Heart Disease
YES NO High Blood Pressure
YES NO Stroke
YES NO Kidney Disease
YES NO Alcoholism (Chemical Dependency)
YES NO Cancer
YES NO Arthritis
YES NO Anemia
YES NO Headaches
YES NO Epilepsy
YES NO Mental Illness

Which of the following OVER-THE-COUNTER medications have you taken in the last week?

YES NO Tylenol
YES NO Advil/Motrin/Ibuprofen
YES NO Decongestants
YES NO Antacid
YES NO Other_____
YES NO Aspirin
YES NO Laxatives
YES NO Antihistamines
YES NO Vitamins/Mineral Supplements

CURRENT MEDICATIONS (includes non-prescription products)

Drug	Dose	Frequency	Drug	Dose	Frequency
1.			2.		
3.			4.		
5.			6.		

How much caffeinated coffee or caffeine containing beverages do you drink per day? _____

Do you use cigarettes or smokeless tobacco, if yes how much per day? _____

How many days a week do you drink alcohol? _____

If one drink equals one beer or glass of wine, how much do you drink at an average sitting? _____

How many days per- week do you use mind altering substances not prescribed by a physician? _____

Have you recently noted the following?

YES NO Weight Gain/Loss
YES NO Fatigue
YES NO Fever/Chills/Sweats
YES NO Nausea/Vomiting
YES NO Weakness
YES NO Numbness or Tingling

_____ _____

Patient or Guardian Signature Date Therapist Signature Date

EVANSTON CLINIC
620 W. Cheyenne Dr.
Evanston, WY 82930
Phone: (307) 789-8860
Fax: (307) 789-8394

BRIDGER VALLEY
64 Meadow Street (Urie Mall)
Urie, WY 82937
Phone: (307) 786-4460
Fax: (307) 786-4461

ACKNOWLEDGMENT
NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that a copy of the WYOMING SPECIALIZED PHYSICAL THERAPY, INC. Notice of Privacy Practices is available to me. I further acknowledge and understand that if I have any questions about the WYOMING SPECIALIZED PHYSICAL THERAPY, INC. privacy practices or my rights with regard to my personal health information, I may contact the appropriate person for further information as set forth in the Notice.

_____ _____
Name of Patient (and Patient's Representative, if one) Patient Account #

_____ _____
Signature of Patient (or Patient's Guardian) Date

Staff Use Only:

To Be Used By Office Staff Only If Patient Written Acknowledgement Is Not Obtained.

DOCUMENTATION SUPPORTING GOOD FAITH EFFORT TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name:_____ Patient acct #_____

I hereby certify that on __/__/__(MM/DD/YR), I made a good faith effort to obtain the above patient's written acknowledge of receipt of the Wyoming Specialized Physical Therapy, Inc. Notice of Privacy Practices, but I was unable to do for the following reason(s).

_____
_____
_____

_____ _____
Name of Staff Representative (Print) Signature of Staff Representative Date