THERAPY WEST
Physical Therapy and Sports Medicine

Patient Information Sheet

Patient Information

Patient Name:		Birth Date:	
SSN:		Gender:	
Mailing Address:		City:	
State:		Zip Code:	
Primary Phone:		Work Phone:	
Email Address:		Emergency Contact	
Patient Status:	Single☐ Married☐ Other☐	Condition Related to:	Employment☐ Auto☐ Other☐
Date of Injury:			

Case Information

Pain Site		Referring Physician	
Involved Side		Homehealth Recently:	Yes☐ No☐

Insurance Information

Primary Insurance

Insurance Name:		Insurance ID:	
Insured's Name:		Insured's Address:	(Address)
Insured's Phone:		Insured's Address:	(City) (State) (Zip)
Insured's Gender:		Insured's Birth Date:	
Relationship to Insured:		Insured's Employer:	

Secondary Insurance

Insurance Name:		Insurance ID:	
Insured's Name:		Insured's Address:	(Address)
Insured's Phone:		Insured's Address:	(City) (State) (Zip)
Insured's Gender:		Insured's Birth Date:	
Relationship to Insured:		Insured's Employer:	

Responsible Party

Guarantor:		Relationship to Patient:	
Address:		City:	
State:		Zip Code:	
Date:		Email:	
Guarantor Signature	______________________________		

Office Use Only

Patient Information ☐	Verification ☐	Reminders ☐	Document Reminders ☐
Current Case ☐	Authorization ☐	Script ☐	
Payer (Add Insurances ☐	Claim Form ☐	Financial Cap ☐	

Consent and Conditions of Service Form

Patient Name (Last, First, MI)	Date of Birth (MM/DD/YYYY	(Office Use Only) Witness Initial:

Welcome to Therapy West Rehab Agency (TWRA). Thank you for choosing TWRA to be your therapy provider. Our therapists are licensed and trained to use evaluation and treatment techniques to help restore you to your optimal activity level. As with all medical care, we are obligated to inform you that there are potential risks associated with treatment. Since the physical response to therapy can vary widely from person to person, it is not always possible to predict your response to certain exercises or procedures. It is possible that therapy may cause pain, injury, or may aggravate previously existing conditions. We encourage you to communicate openly with your therapist during the evaluation and treatment process. You have the right to decline any portion of your treatment at any time before or during a treatment session.

Release of Information and HIPAA/Privacy Acknowledgment: TWRA is required by law (Office of Civil Rights) to protect the privacy of your medical records. TWRA uses and discloses medical records ONLY in accordance with state and federal privacy laws (HIPAA). Uses and disclosures are described in TWRA Notice of Privacy Practice. You may request a copy of this document at any time.

I acknowledge that I have been offered a copy of the TWRA Notice of Privacy Practice. **Initial __________**

Patient Medical Record Authorization:
I authorize TWRA to provide my confidential information to the following individual(s).

Name____Relationship to Patient________________________

Name____Relationship to Patient________________________

Appointment Reminders: I authorize TWRA to send me appointment reminders via text, email and or phone.

Initial __________

I understand and agree that a $25.00 fee will be assessed if I do not provide a cancellation notice before the end of the business day prior to a scheduled appointment. Assess fees must be paid prior to receiving the next treatment.

Initial __________

Financial Responsibility: I (Patient or Authorized Representative) agree to pay for any amounts not paid by an insurance company or other third party payer (excluding contract discounts) for care provided. I understand that I am responsible for all co-payments, deductibles, co-insurances, and/or non-covered services. I also agree to pay a Same-Day-Rate OR published Piece Rates for care provided when or if I choose to not have my insurance billed.

Initial __________

Unresolved Account Balance:
I understand that I carry the full responsibility of any unresolved balance and I understand and agree that any remaining balance on my account not paid within 30 days of the statement date or according to terms of a payment plan will be sent to a collection agency. If I choose not to pay for care provided and in the event an unpaid balance is placed with a collection agency or attorney, I agree to pay the unpaid balance and associated collection fees.

Initial __________

For Medicare/Medicaid/Tricare/Veterans Administration Patients's Certification Only: I certify that the information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act, or in connection with any other government program, is correct. I authorize TWRA to release documentation regarding my therapy services to the Social Administration, fiscal intermediary, insurance payer, or state agency in order to process a claim for my therapy services.

Initial __________

Assignment of Benefits: I request and authorize my health insurance carrier to pay TWRA directly for all charges related to services provided to me by TWRA or other providers who have authorized TWRA to bill on their behalf.

Initial __________

My initials above, and signature below, acknowledge that I have read, understand, and agree to the terms of this authorization form and give my consent to proceed with a therapy evaluation and corresponding treatment.

I understand that I am entitled to request and obtain a copy of this document. This document will remain in effect unless revoked in writing by the Patient or Authorized Representative.

Signature:	**Date:**
Printed Name:	**Social Security Number** (Patient or Signee):
If signee is someone other than the patient please fill out the information below:	
Relationship to Patient:	**Date of Birth of Signee**

Statement of Rights and Responsibilities

You have the right to:

1. Be treated with dignity, courtesy and respect.

2. Receive competent, quality services regardless of age, race, sex, national origin, religion, disability or any category protected by the law.

3. Expect Therapy West to coordinate your care through regular communication with your physician, caregivers, and other providers.

4. Receive an explanation of any responsibilities you or your family/caregivers may have in the care process.

5. Request the information practices utilized by Therapy West, pc. regarding the use and disclosure of your Protected Health Information (PHI). You may request a review of this description prior to signing this statement. You may request restriction on used and disclosures of your PHI.

You have the responsibility to:

1. Provide complete and accurate information about your health.

2. Provide 24 hours notice in the event of a cancellation. There is a $20 charge for a cancellation without proper notice. This charge will not be covered by insurance and will have to be paid by you personally.

3. For Worker's Compensation and Personal Injury patients' documentation of any missed appointments is forwarded to your Case Manager and Primary Physician. This could jeopardize your claim.

4. Communicate closely with your physical therapist regarding any increase or decrease in symptoms. Neither a increase or a decrease in symptoms is reason to discontinue therapy, this decision should be a joint decision between you and your therapist.

5. Attend your last scheduled visit. Recent changes in policies with insurance companies and Medicare require that your last visit be categorized a discharge visit. Please attend your last scheduled visit so we can comply with your insurance requirements; failure to do so may jeopardize your insurance benefit.

I understand that my Protected Health Information means health information, including my demographic information collected from me and created or reviewed by my physician, therapist, another healthcare provider, a health plan, my employer, or a healthcare clearinghouse. This protected Health Information relates to my past, present, or future physical or mental health or condition.

I consent to the use or disclosure of my Protected Health Information by Therapy West for the purpose of diagnosing or providing treatment to me. I voluntarily consent to receive therapy services provided by Therapy West, pc. I further consent to the use or disclosure of my Protected Health Information by Therapy West, pc. for the purpose of obtaining payment of my healthcare bills from authorized insurance, prepaid medical plans, Medicare, or Medicaid to Therapy West, pc.

______________________________ ______________________________

Patient Signature Date

______________________________ ______________________________

Interviewer Signature Date