McGuire Physical Therapy

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for McGuire Physical Therapy to furnish physical therapy care and treatment to

Print Name: _____considered necessary and proper in treating their physical condition.

BENEFIT ASSIGNMENT / RELEASE OF INFORMATION

I, hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance and any other health plans to McGuire Physical Therapy. A photocopy of this assignment is to be considered as valid as the original. I, hereby authorize said assignee to release all information necessary, including medical records, to secure payment.

FINANCIAL POLICY STATEMENT

It is our policy to bill your insurance carrier as a courtesy to you, although you are responsible for the entire bill when services are rendered. We require that arrangements for payment of your responsible co-payment and/or deductible be made today. If your insurance does not remit payment within 90 days, the balance will be due in full from you.

If any payment is made directly to you for those services billed by us, you recognize an obligation to promptly remit the same to McGuire Physical Therapy.

The above does not apply for those patients that are considered Workers Compensation. However, be advised as a Compensation patient that you may be held responsible for your charges in the event your claim is controverted.

I understand and agree that if I fail to make any of the payments for which I am responsible that I will also become responsible for all costs incurred in the collection of these fees.

___ I acknowledge that the HIPAA regulations for McGuire Physical Therapy are available for my review in the waiting room.

WE HAVE VERIFIED YOUR BENEFITS WITH YOUR INS. CO.

Per your insurance "this is not a guarantee of payment, benefits are subject to all contract limitations and members' eligibility status on the date of service.

Primary Insurance: _____ Secondary Insurance: _____

Deductible responsibility will be $ _____ per _____ visit(s).

Once deductible is met, there will be $ _____ copay each visit after. Visit Limit _____.

___ I understand that I am responsible for any deductibles, co-pays, or coinsurance that my insurance states is my portion.

___ I understand that No Shows or same day Cancellations of Appointments will result in a $25 charge that is NOT covered by my Insurance.

_____ _____

Patient or responsible party signature **Date**

McGuire Physical Therapy
PATIENT INFORMATION

Preferred Language: _____

Patient Name: _____ DOB: _____ Gender: M / F

Address: _____ City: _____ Zip Code: _____
Home Phone: (_____)_____-_____ Cell: (_____)_____-_____ Work: (_____)_____-_____
Employer: _____ E-mail: _____
DriverLicence/IDNumber:_____ExpDate:_____SSN:_____-_____-_____

Emergency Contact Name: _____ Relation: _____ Phone Number: _____

***If patient is under 18**: Guarantor Name: _____ DOB: _____

Authorized Contact for Release of Medical Information

Authorized Contact Name: _____ Relation: _____ Phone Number: (_____)_____-_____
☐All physical therapy medical records ☐Changes to schedule (IE: scheduling/canceling and rescheduling appointments)

History

In order of severity, where do you hurt most:_____

Between 0 and 10 rate your **average** level of pain: (Best) 0 1 2 3 4 5 6 7 8 9 10 (Worst)

Between 0 and 10 rate your **worst** level of pain: (Best) 0 1 2 3 4 5 6 7 8 9 10 (Worst)

Name of your PCP or referring doctor(s):_____
Approximate date of when symptoms started: _____ What was your onset of pain: ☐Sudden or ☐Gradual

Have you ever had surgery? Yes ☐ No ☐ If yes, what kind of procedure and when?_____
Have you had any recent x-rays or MRI's taken? Yes ☐ No ☐If so, when and where? _____

Have you ever had any of the following?

☐High Blood Pressure ☐Breathing Problems ☐Pacemaker ☐Dizzy Spells ☐Seizures
☐Heart Trouble ☐Fractures ☐Claustrophobia ☐Diabetes
☐Circulation Problems ☐Stroke ☐Trouble with Vision ☐Arthritis
Do you have any metal in your body (other than teeth): Yes ☐ No ☐ Are you currently pregnant? Yes ☐ No ☐

Please list any allergies:
_____

Please list any medications you are currently taking:
_____
_____