Millennium Physical Therapy Rehabilitation & Wellness

PATIENT INFORMATION

First Name: _____ Last name: _____ Middle Initial: _____

Address:_____ City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home/Work Phone: _____ E Mail: _____

May we leave you a voice/text message ____Yes or ____No If 'No', alternative phone: _____

Birth Date: _____ Age: _____ Gender: _____Female _____Male _____Other

Marital Status: ____Married ____Single ____Divorced ____Widowed Emergency Contact Name: _____

Relationship: _____ Emergency Contact Phone: _____

Referring Physician: _____ Phone: _____ Fax: _____

Primary Care Physician: _____ Phone: _____ Fax: _____

How did you hear about us? (Check all that apply)

Family/Friend____ Previous patient____ Website____ Facebook____ Internet search____ Billboard____ Direct-Mail____

Insurance/Billing Information

Primary Insurance : _____ ID#:_____ Group: _____

Secondary Insurance : _____ ID#:_____ Group: _____

Please complete the following only if subscriber is not the patient or is a minor: **Relation to Subscriber:** (circle one)

Subscriber Name: _____Date of Birth: _____ Spouse Child Other

Employer: _____ Employer Phone: _____

Employer Address: _____ City: _____ State: ____ Zip: _____

Are services related to a work or auto injury? (Please circle one if applicable): **Work or Auto**

Date of injury: _____ Claim Number: _____ NCM or Adjuster Name: _____

Insurance Carrier: _____ Telephone: _____ Ext: _____

Employer: _____ Supervisor or Contact Name: _____

Employer Address: _____ Employer Phone: _____

Email: I give permission to Millennium Physical Therapy to send me email messages regarding upcoming appointments and promotions. We will not sell or distribute your email address to any other entity. **Initial:** _____

Notice of Privacy Practice: Your personal health information (PHI) is protected and is used exclusively to administer physical therapy services and process your claims. Unauthorized disclosure of PHI is strictly prohibited. A complaint can be filed with the Privacy Officer in person or in writing at any time you feel your PHI is not being protected and the complaint will be met with full respectful attention without retaliation.

Our Notice of Privacy Practices is posted at the front desk for your review. We are happy to give you a copy if you would like a copy for your records. This describes in more detail how your health information may be used and disclosed, and how you can access your information. **Initial:** _____

_____/_____

Signature (Guardian must sign if minor) Date

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Assignment of Benefits:

I hereby assign all medical benefits, to include major medical health benefits to which I am entitled, including Medicare, private insurance, and any other health plan to Millennium Physical Therapy. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to consider as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment. If I receive direct payment from my insurance company for my treatment, I will be responsible to bring this payment to Millennium Physical Therapy to be applied to my account for services rendered. I certify this information is true and correct to the best of my knowledge. **Initial:** _____

Authorization for Release of Medical Records:

Millennium Physical Therapy is authorized to provide and request from my referring physician, other physicians and/or my attorney, information regarding my diagnosis and medical condition for physical therapy while under their treatment. Information to be disclosed may include nature of the physical impairment, history, contributing factors, subjective symptoms, diagnosis, prognosis, and other information pertinent to my treatment. Photostatic copy of this authorization shall serve in its stead. **Initial:** _____

Consent to Evaluate and Treat:

I, consent to evaluation and treatment by Millennium Physical Therapy.
(If patient is a minor, parent or guardian must sign below.)

Signature: _____ **Date:** _____

NO SHOWS/LATE CANCELLATIONS:

Millennium Physical Therapy strives to provide all our patients with the best possible care. In order to provide this care and for you to achieve your goals for recovery, it is essential that you keep all scheduled appointments.

- In order to do this, we are requesting that you provide us with a 24hour cancellation notice. Failure to provide this notice prevents us from helping other patients during the time that you did not use. Therefore, failure to provide us with 24hour notice will result in a charge of $25.00 for each missed visit. This missed appointment fee is not covered by your insurance plan and will be billed to you directly and payable at the next office visit. **Initial:** _____

- If you no show for a scheduled appointment, all subsequent scheduled appointments may be cancelled and will need to be rescheduled. **Initial:** _____

- Additionally, if a patient is 15 minutes late to his/her appointment, we reserve the right to cancel the appointment. **Initial:** _____

We do realize that on rare occasion emergencies or circumstances may arise beyond your control. We are sensitive to this fact and will address this as needed at the time of occurrence.