General Office Information

Welcome to Rankin Physical Therapy, Inc. We look forward to serving your physical therapy needs and wish you a speedy recovery

Cancellation Policy: Due to over whelming amount of no shows, a cancellation policy will be effective February 2, 2004. Patients must give notice prior to their appointment time, preferably 24-hours, in order to maximize physical therapist time. Please note, a $20.00 fee will be charged to those individuals who do not show without prior notice for three scheduled appointments.

Billing Policy: Our billing company will make every effort possible effort to accurately submit claims to your insurance company. In order to process your claims, we require referrals, claim forms, and other necessary paperwork to be brought at the time of your appointment. Any balances following insurances processing will be computed according to the policies and constructional obligations of the insurance company and will be mailed to you at the beginning of each month in statement format. Payment is expected upon receipt. Should there be questions or concerns regarding your statement, please contact the billing department at your earliest convenience

I have read the GENERAL OFFICE INFORMATION and agree to the terms.

X_____ _____

Signature **Date**

Authorization and Assignment of Benefits

I, _____, hereby authorize Rankin Physical Therapy, Inc. to apply to _____, for benefits on my behalf for services rendered by Rankin Physical Therapy, Inc. and request that the payments are made directly to them. I certify that the information I have reported about my insurance coverage is correct. I also authorize Rankin Physical Therapy, Inc. to release all necessary information, including medical information for this and any related claim, in order to determine benefits to which I am entitled. I permit a copy of the authorization to be used in place of the original. Furthermore, I understand that I am ultimately responsible for the services rendered.

X_____ _____

Signature **Date**

Acknowledgement of Receipt of Notice of Privacy Practices

Patient: _____ _____ ____ _____

Last Name First Name MI Date of Birth

In general, any information that is about your health care you receive, or payment for that care is considered confidential and protected by our practice. We may need to use your protected health information to carry out treatment, payment of healthcare operations and/or other purposes. Our Notice of Privacy Practices provides a more complete description of permitted uses and disclosures.

☒ I knowledge that I have reviewed a copy of the Notice of Privacy Practices

X_____ _____

Signature of Patient or Responsible Party **Relationship to Patient if Applicable**

_____

Date

FOR USE ONLY BY A REPRESENTATIVE OF Rankin Physical Therapy

A good faith effort was made to obtain a written acknowledgement of receipt of our Notice of Privacy Practices that was provided to (circle one) the patient/the patient's representative on ____I____I____.

This acknowledgement was not obtained for the following reason(s): _____

_____

_____

Signature of Representative: _____

RANKIN PHYSICAL THERAPY

PATIENT HISTORY

Name: _____ DOB: _____ Age: _____
Sex: M / F Occupation: _____
Family Physician: _____ Date of return visit : _____
Other Physician: _____ Reason :_____
List all medications and what they are for: _____
_____

Past Medical History - Check all that apply:

- ☐ AIDS
- ☐ Allergies
- ☐ Bowel or bladder incontinence
- ☐ Breathing problems/asthma
- ☐ Cancer
- ☐ Pregnant now
- ☐ History of back/neck problems
- ☐ Fibromyalgia
- ☐ Anxiety/Depression
- ☐ Dizziness
- ☐ Fainting spells
- ☐ Headaches
- ☐ Heart/circulatory disease
- ☐ Heart Attack
- ☐ Stroke
- ☐ High blood pressure
- ☐ Pacemacker
- ☐ Osteoporosis
- ☐ Recent weight loss/gain
- ☐ Degenerative arthritis
- ☐ Rheumatoid arthritis
- ☐ Seizures
- ☐ Steroid use
- ☐ Dental problems/jaw pain
- ☐ Diabetes
- ☐ Blood clots or history of
- ☐ Other _____

List any surgeries with dates:
_____
_____

Current Medical History:

Describe relevant symptoms: _____
Present since: _____/_____/_____ ☐ Improving ☐ Unchanging ☐ Worsening
Improved as a result of : _____ or no apparent reason
Symptoms at onset: _____
Constant symptoms: _____
X-Rays/Other Imaging: _____

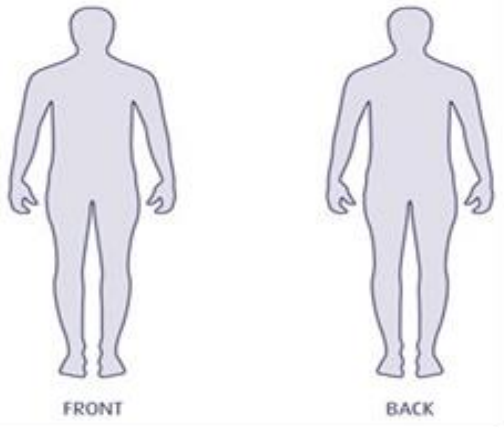
Circle the number to describe the severity of your symptoms:

0 1 2 3 4 5 6 7 8 9 10 (0= No Pain / 10= Most excruciating pain imaginable, unable to sit still)

Circle any descriptions of your symptoms:

Burning Tingling Sharp Dull Deep Achy Other: _____

My symptoms improve with: _____
My symptoms worsen with: _____
List any previous treatments for this condition, if any: _____
_____
Please indicate on the diagrams where your major area(s) of pain are, and date symptoms began: _____



Patient Signature: _____

Therapist Signature: _____

Rankin Physical Therapy
Patient Information

Patient's Name:_____ Home Phone ( ) _____

Street Address: _____ Work Phone ( ) _____

City: _____ State: _____ Zip: _____

Employer & Address: _____

Email Address: _____

Birth Date: _____ SS#: _____Sex: _____ Marital Status: _____

Emergency Contact: _____ Phone # ( )_____

Health Insurance Information

Primary Insurance:_____ Copy made: ☐ Yes ☐ No

Secondary Insurance: _____ Copy made: ☐ Yes ☐ No

Card Holders: Name: _____ SS# _____ DOB #: _____

General Information

Date of Onset/Injury: _____ Referring Doctor: _____ Phone: ( ) _____

Is this injury work or accident related? ☐ Yes ☐ No (If yes, please complete the following)

Workman's Compensation Claim #: _____ State: _____

Address where claims are to be mailed: _____

Contact: _____ Phone Number: _____

Auto Accident Carrier: _____ Phone: ( ) _____

Address where claims are to be mailed: _____

Claim # _____ Adjusters Name: _____

Do you have an attorney for this claim? ☐ Yes ☐ No (If yes, please complete the following)

Attorney's Name: _____ Phone: ( ) _____

☐ Letter of protection received