Atlantis Physical Therapy Associates

Date Called/Walk-In: _____

Appointment Date: _____
Time: _____**PT/OT:** _____
Diagnosis/ICD9/Body Parts: _____
Frequency & Duration: _____ **X** _____
Ins Type: (Circle One) **PVT MC CASH**
Auto/WC(on the Back)

Referring Doctor: _____
Dr. Phone#: _____**Fax:** _____
NPI: _____
Addresss: _____
_____

Patient Information

Last Name: _____First Name: _____ M.I.: ____ **Date of Birth:** __ _____

Address: _____ Apt.#.____ City: _____ State: ___ Zip Code: _____

Home Phone#: _____ Cell Phone#: _____ E-mail Address: _____

SS#: _____ Sex: M__ F__ Driver's License#: _____

Marital Status: M___ S___ D___ W___ Spouse's Name: _____

Emergency Contact: _____ Phone#: _____

Patient Work Information

Employer's Name: _____

Employer's Address: _____ City: _____ State: ____ Zip Code: _____

Work Phone #: _____Ext.#: _____ Employer's ID#: _____ Occupation: _____

Please Check"√" all that applies to you: Is this Related to: Work _____ Auto _____ Date of Injury/Accident: _____
Attorney involved? Yes___ No___
Name: _____ Phone#: _____
Address: _____City: _____State _____Zip Code _____

Medicare Number (*if Applicable***)** _____

Private Insurance Information

Date Verified: _____ **Phone Number:** _____ **Verified By (Ins Rep.)**_____
Reference Number: _____
Effective Date of Coverage: _____ **Are we contracted?: Yes** _____ **No**_____

Insurance Company_____ Certificate ID#: _____Group#:_____

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

****Is this your coverage? Yes __No __ If no, whose name is covered?** _____ **Relationship:** _____**Insured's Date Of Birth:** _____

Deductible: $_____Contract Yr _____Calendar Yr? Amount Met? $_____Copay: $_____

Benefits: _____Coins.: _____ Max out of Pocket $_____ Met $_____

Limitations: _____

Visits Allowed: _____Used:_____ Consecutive or Calendar Yr? Combined w/OT,PT,CHIRO,etc…?_____

Do we need authorization to begin therapy? _____ If yes, Phone#: _____

Patient's Signature: _____ ***Date:*** _____

Auto Insurance Information

Auto Insurance Company Name: _____Name of Insured: _____Date of Birth: _____

Address: _____City: _____State: _____ Zip Code: _____

Policy Number: _____ Claim Number: _____ Date of Accident: _____

Adjustor's Name: _____ Phone Number: _____Fax Number: _____

Worker's Compensation Information

Employers Name (at time of injury): _____ Phone Number: _____

W/C Insurance Company Name: _____

Address: _____City: _____State: _____ Zip Code: _____

Claim Number: _____ Date of Injury: _____

Adjustor's Name: _____ Phone Number: _____Fax Number: _____

Nurse Case Manager: _____ Phone Number: _____Fax Number: _____

Review Co.: _____ Phone Number: _____Fax Number: _____

Record of Communications:

Date:	

AUTHORIZATION TO PAY Atlantis Physical Therapy
Assignment of Benefits

I hereby authorize my insurance benefits to be paid directly to Atlantis Physical Therapy and I am financially responsible for non-covered services. I also authorize Atlantis Physical Therapy to release any information to process this claim.

Signed: _____ Date: _____

ATLANTIS PHYSICAL THERAPY ASSOCIATES, INC.

PATIENT INFORMATION CONSENT FORM

I have read and fully understand ATLANTIS PHYSICAL THERAPY's Notice of Information Practices. I understand that ATLANTIS PHYSICAL THERAPY may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that ATLANTIS PHYSICAL THERAPY will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in ATLANTIS PHYSICAL THERAPY's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____
Patient Name (print)

_____
Signature

_____
Date

Atlantis Physical Therapy, Inc.

Agreement to Pay Contract

The policy of Atlantis Physical Therapy, Inc. (hereafter referred to as "Atlantis") is to expect payment upon rendering professional services, i.e. at the conclusion of the initial appointment, and at the end of each week of treatment thereafter.

Patients are expected to pay at least the unpaid portion of their deductible and the copayment designated by their insurance plan. Payment is accepted by cash, personal check, Master Card or VISA. ATLANTIS will submit patient charges to Integrity Billing Services, who processes the billing to the patient insurance company. Any patient payments are credited by Integrity against the total patient charges. The undersigned also authorizes the release of any medical/personal information necessary to process insurance claims on the patient's behalf.

Patients should understand that authorization on benefits for therapy services does not guarantee payment by the insurance company. Therefore, in the event of non-payment for services by the insurance company, the undersigned assumes total responsibility for payment in full.

The undersigned further understands and agrees that he/she will be responsible for any legal fees, collection fees, and court costs, in addition to any outstanding balances owed to ATLANTIS, in the event ATLANTIS finds it necessary to pursue legal action to collect monies due ATLANTIS by undersigned.

The undersigned agrees to pay ATLANTIS a $25.00 fee for the return by a depository institution of any dishonored check or negotiable order of withdrawal issued in connection with services rendered by ATLANTIS.

_____

Initials **The undersigned understand that ATLANTIS charges $25.00 for appointments missed and not cancelled with a 24 hour notice.**

ATLANTIS reserves the right to refuse treatment to the undersigned by reason of the undersigned's failure to adhere to the above stated policies.

_____ _____

Signature Date

I authorize payment of benefits to ATLANTS Physical Therapy Associates, Inc. for payment of services rendered.

_____ _____

Signature Date

Co-Pay Amount: $_____

Co-Insurance Amount: _____%=Approximate $_____ per visit. Please note that this is an approximation. Payment might be more or less depending on your insurance. Deductible: $_____ Amount met$_____ Amount still owed: $_____

ATLANTIS PHYSICAL THERAPY ASSOCIATES, INC.
PATIENT MEDICAL INFORMATION

Name: _____ Birthdate: _____ Date: _____

Occupation/Employer: _____ Work Status_____

Exercise/Sports/Hobbies: _____

HEALTH HISTORY
Please check "✓" all that applies to you

ORTHOPEDIC
- ☐ Amputation
- ☐ Arthritis
- ☐ Arthroscopic Surgery
- ☐ Back Pain / Surgery
- ☐ Carpal Tunnel Syndrome
- ☐ Foot Pain / Surgery
- ☐ Fractures
- ☐ Frozen Shoulder
- ☐ Hand Pain / Surgery
- ☐ Knee Pain / Surgery
- ☐ Neck Pain / Surgery
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Rotator Cuff Tear / Repair
- ☐ Spinal Stenosis
- ☐ Total Joint Replacement
- ☐ Other_____

NEUROLOGICAL
- ☐ Balance Problems
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Headaches
- ☐ Hearing Impairment
- ☐ Memory Impairment
- ☐ Multiple Sclerosis
- ☐ Neuropathy
- ☐ Paralysis
- ☐ Parkinson's Disease
- ☐ Reflex Sympathetic Dystrophy (RSD)
- ☐ Seizures
- ☐ Spinal Cord Injury
- ☐ Stroke / Brain Injury
- ☐ TIA
- ☐ Vertigo
- ☐ Vision Impairment

Other_____

RHEUMATOLOGY
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Lupus Erythematosis
- ☐ Rheumatoid Arthritis

CARDIOVASCULAR
- ☐ Angina
- ☐ Congestive Heart Failure
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Irregular Heart Beats
- ☐ Open Heart Surgery
- ☐ Pacemaker
- ☐ Other_____

RESPIRATORY
- ☐ Asthma
- ☐ COPD
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Pulmonary Embolism
- ☐ Shortness of Breath
- ☐ Tuberculosis
- ☐ Other _____

OTHER MEDICAL
- ☐ Allergies
- ☐ Bladder Problem
- ☐ Bowel Problems
- ☐ Cancer
- ☐ Colitis
- ☐ Depression
- ☐ Diabetes
- ☐ Female Problems
- ☐ GERD (Reflux Disease)
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Hysterectomy
- ☐ Kidney Disease / Dialysis
- ☐ Pelvic Pain
- ☐ Prostate Problems /Surgery
- ☐ Shingles
- ☐ Skin Infections
- ☐ Thyroid Disease
- ☐ Other_____

PLEASE CONTINUE ON REVERSE

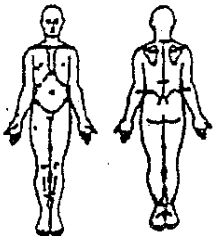
ATLANTIS PHYSICAL THERAPY HEALTH HISTORY (continued)

1. What is your current complaint? _____

2. What happened to cause this problem? _____

3. When did this present condition begin? _____

4. Circle area of symptoms on drawing below: 0=None 10=Severe



On a 0-10 scale what is the LEAST amount of pain you have? ____
On a 0-10 scale what is the MOST amount of pain you have? ____
On a 0-10 scale what is your PRESENT pain? ____

Aggravating Activities: _____

Easing Activities: _____

5. Please circle the activities that are difficult because of pain: sit stand walk get out of chair bend lift carry stairs drive sleep dress other: _____

6. Any recent diagnostic test and/or x-rays (related to this condition)? X-Ray __ Bone Scan __ MRI__ CAT Scan __ EMG ___ Nerve Conduction Test___ Other_____
   Results: _____

7. What treatment(s) have you received for this present condition? None __ Injections__ Chiropractic__ Physical Therapy __ Acupuncture __ Other _____ When were you treated? _____

8. Have you had this diagnosis before? Yes___ No___ If "yes" how was it treated? _____
   Was this treatment successful? Yes___ No___

9. Current Medications: _____

   _____

10. Are you a smoker? Yes___ No___

11. Are you pregnant? Yes___ No___

12. Have you fallen (in the past year)? Yes? __ No? ___ If "yes," how many times? _____

13. Do you have surgical implants/pacemaker? Yes___ No___

14. What are **YOUR GOALS** for receiving therapy?

    a. _____ b. _____

15. Are you currently receiving Home Health Care? Yes___ No___

16. Why did you choose ATLANTIS for your treatment?
    Prescribed by your physician___ Recommended by friend, family, former patient ___
    Recommended by employer ___ Advertising (e.g. Yellow Pages) ___
    You are a former patient ___ Other_____