The Edge Physical Therapy

Patient Information

Patient Name: _____ DOB: _____ Sex: _____

Address: _____ Home/Cell Phone: _____

City & State: _____ SSN: _____ Marital Status: _____

Employer: _____ Work Phone: _____

Date of Injury or illness_____ Job Related_____ MVA Related_____ Other_____

Emergency Contact Information: _____ Home/Cell Phone: _____

Responsible Party

Name: _____

Address: _____

Address: _____

Home/Work Phone: _____

Insured Date of Birth: _____

Insurance Information

Insured Name: _____

Insurance Name: _____

Policy Number: _____

Group Number: _____

Diagnoses: _____ Referring Physician: _____

Medical Information

Does your current medical history include the following:

	Yes	No		Yes	No
1. Anemia	☐	☐	11. Pregnancy	☐	☐
2. Diabetes	☐	☐	12. Lung Disease	☐	☐
3. Allergies	☐	☐	13. Mental Illness	☐	☐
4. Arthritis	☐	☐	14. High Blood Pressure	☐	☐
5. Abnormal Heart	☐	☐	15. Hepatitis	☐	☐
6. Ulcers	☐	☐	16. Pace Maker	☐	☐
7. Epilepsy/Seizures	☐	☐	17. Circulation Problem	☐	☐
9. Kidney Problems	☐	☐	18. Hemophilia	☐	☐
10. Cancer	☐	☐	19. Burn Injuries	☐	☐

Any other Illness (Please describe): _____

_____

List any past surgeries: _____

Briefly describe your symptoms: _____

List of current medications you are taking: _____

Are you entitled to Medicare? Yes · No ·

If yes, are you currently receiving home health for any reason? Yes · No ·

Please complete each question on the front of this page and after completion please return to the front desk. Thank you

Credit Policy & Assignment of Benefits

If you have health insurance, it should be understood that this is an agreement between you and your insurance company. Your therapy bill is an agreement between you and The Edge Physical Therapy. Statements will be provided monthly. Any copays or co-insurance amounts or other patient responsibilities not covered by your insurance company will be your responsibility. Copays will be due at time of service rendered. You will also be responsible for the payment of your bill regardless of the status of your insurance claim.

Most Insurance companies do not cover durable goods/supplies; therefore you are responsible for any durable goods/supplies you receive. Payment is required upon purchase unless prior arrangements are made with our business office.

Charges for medical services at our clinic are billed monthly as a courtesy to our patients. We accept Visa, Mastercard, Discovery cards, cash, check and money orders. A payment of $50.00 is required at least every 30 days; and balance paid within year of completion of treatment. There is a monthly payment plan available if unusual circumstances make it impossible to meet our credit terms, we invite you to call and personally discuss the matter with our office.

Authority to Treat

Permission is hereby granted to The Edge Physical Therapy, to perform treatment of physical therapy modalities as deemed necessary by a licensed physical therapist.

Authority to Release Information

Permission is hereby granted to The Edge Physical Therapy for the release of my medical records to authorized representatives.

Medicare Policy

I certify that the information given by me applying for payment under title IVIII of Social Security Act is correct, I authorize any holder or medical or other information about me to be released to the social security administration or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf to The Edge Physical Therapy Clinic. I agree to pay all deductible and co-insurance amounts not reimbursed for services rendered.

I, the undersigned, have read and understood the above authority to release information, authority to treat, authority to release information and the credit policy and assignment of benefits and Medicare policy. I hereby agree to the terms terein.

Date: _____ Patient Name: _____

Witness: _____Responsible Party Signature: _____

The Edge Physical Therapy
Notice Privacy Practices

The Edge Physical Therapy implements the privacy practices for protected health information guidelines from The Health Insurance Portability and Accountability Act (HIPAA) of 1996. We do not release any information without your written request. The Edge Physical therapy also protects your information from possible identity theft; we follow the Red Flag guidelines which protects your information.

_____ _____

Print Name of Patient Date

_____

Signature of Patient

_____

Relationship of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign the form)

Appointment Cancellation Policy

The Edge is committed to providing optimal care and exceptional customer service. To accomplish this, it is extremely important that you attend each of your scheduled appointments. We value your appointment time and this time slot is specifically set aside for you.

Failure to keep your scheduled appointments at The Edge Physical Therapy hinders our ability to provide the best care to our patients. So, to limit missed appointments, we have implemented a "No-Show/Late Cancellation Fee."

We ask that you show us consideration by calling at least 24 hours prior to your appointment if you are unable to attend. This will allow us the opportunity to offer that appointment to another patient. Please call The Edge Physical Therapy at: **(318) 841-0696**.

- We require 24 hours advance notice of appointment cancellation
- In the event of a late cancellation or "no-show," your account will be assessed a $25 cancellation fee
- Three cancellations or no-shows during the course of therapy require your therapist to discharge you from therapy. In the event that you are discharged from our care, your referring provider or case manager will be notified of the reason for discharge from physical therapy.
- Late cancellations due to illness or family emergency are excluded from this policy.

At The Edge Physical Therapy, failure to give the 24 hours notice necessary prior to cancellation will result in a "No-Show/ Late Cancellation Fee." **This fee cannot be billed to your insurance company and will be your direct responsibility.**

The No-Show/ Late Cancellation Fee is as follows:

Physical Therapy Appointment No Show/ Late Cancellation Fee-
$25 to be paid at time of next visit

I understand The Edge Physical Therapy's appointment cancellation policy and understand my responsibility to plan appointments accordingly and notify The Edge Physical Therapy appropriately if I have difficulty fulfilling my scheduled appointments.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date