PATIENT INFORMATION SHEET ACCT# PT

Patient name: (last/first/middle): ____

Date of birth: ____________________ Age: __________ Please circle: Female Male

Height: ________________________ Weight: ______________________ **(insurance requires both)**

Address: ____ Patient/Responsible party SS#: _______

City: ____ State: _______ Zip: _______________

Home phone: ____________________________________ Cell: ___________________________

Email address: ___________________________________ Driver's License#: ________________

Employer: _______________________________________ Occupation: ______________________

Marital Status (please circle): Married Single Divorced Widowed

Emergency Contact: _____________________________ Phone:______________________________

Primary Insurance: ____

Secondary Insurance: ____

(SEVEN OAKS WILL ONLY BILL SECONDARY INSURANCE IF WE ARE CONTRACTED PROVIDER)

Referring Physician: ______________________________ Body part: _______________________

Onset date of symptoms/Date of injury/ Date of surgery: ________________ **(insurance requires)**

Type of illness (please circle): Home Work Sports Auto

How did you hear about Seven Oaks Physical Therapy? ____

I DO HEREBY ASSIGN all insurance benefit to be paid directly to Seven Oaks Physical Therapy for all medical services provided to me. I also acknowledge that I am personally liable for all charges incurred by me for treatment services provided me by Seven Oaks Physical Therapy. I further authorize Seven Oaks Physical Therapy to release information required regarding the course of my treatment, for the purpose of evaluating and administering claims for benefits. I understand I am responsible for services not covered by my insurance, i.e. benefits exhausted or do not meet the criteria of medical necessity per my plan's guidelines. I have been informed of and agree to abide by the cancellation policy. ANY PERSONAL BALANCE 30 DAYS OR MORE PAST DUE MAY BE SUBJECT TO A 1.5% FINANCE CHARGE.

____

Signature of patient/Parent/Responsible party Date

MEDICAL HISTORY

THE FOLLOWING QUESTIONS MUST BE ANSWERED

For what condition/symptoms are you being seen for at this time? ________________________________

When did this condition begin? ____

What treatment have you already received? ____

Has this problem occurred in the past? ____

Have you had one or more falls in the past year/fall resulting an injury in the past 12 months? YES NO

MEDICATION (please list all current medications, dosage/frequency of use or provide list of medications):

Medication **(insurance requires)**	Dosage/frequency of use **(insurance requires)**
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

SURGERIES/FRACTURES/OTHER SERIOUS INJURIES (Please list previous surgery/indicate date)

Surgery/Procedure	Date/Approximate Age
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

PAST MEDICAL HISTORY (please circle if applies)

Heart Disease/Heart Attack	Peptic Ulcer/Pancreatitis
Rheumatic Fever	Anemia/Blood disorders
High Blood Pressure	Tuberculosis
Stroke	Jaundice
Epilepsy/Convulsions	Hernia
Kidney/Bladder problems	Thyroid Disorders
Diabetes	Venereal Disease
Tumor/Cancer	Genital Disorders
Congenital Abnormalities	Respiratory Disease/Asthma
Pregnant YES/NO	Pacemaker YES/NO
Surgical Implants YES/NO	

FAMILY HISTORY

- Heart Disease
- Cancer
- Arthritis
- High Blood Pressure
- Gout
- Bleeding Tendency
- Diabetes
- Stroke

ALLERGIES (please circle): Penicillin Morphine/Codein Novacain/local anesthetic Other

Patient name: ____

INFORMED CONSENT FOR PHYSICAL THERAPY TREATMENT

This form is an effort by Seven Oaks Physical Therapy to provide you with information about your physical therapy treatment here at Seven Oaks that is administered by a licensed physical therapist, physical therapy assistant or other ancillary personnel. The purpose of “informed consent” is to provide you with sufficient information so that you can make an “informed” decision regarding your consent to physical therapy treatment. It is our goal to provide you with appropriate and safe treatment that will result in an improvement in your particular condition. However, because there are many factors and issues involved in a specific individual’s medical condition and treatment we are unable to guarantee that every individual medical condition will respond positively to treatment.

Physical Therapy involves many types of treatments, procedures and modalities. The type of treatment the therapist incorporates into your treatment care plan is generally based on the information gleaned from the prescription of your referring physician, your initial evaluation and your response to various types of procedures employed during your treatment. Your treatment may be altered or changed by the therapist based on your response to current treatment and as your condition changes. There are benefits and risks associated with all types of medical treatment and this includes physical therapy. While it may be possible to make an extended list of potential risks from all types of physical therapy treatment it is not practical nor is it likely to result in providing you with information that allows you a better understanding of “risks vs. benefits”. We encourage you to ask your therapist about any concerns or questions you may have regarding your treatment. He or she will be glad to discuss and review any particular treatment that you are receiving.

Manual therapy (includes joint mobilization, soft tissue mobilization and manual traction) and therapeutic exercise are frequent procedures utilized at Seven Oaks that we believe provide our patients with significant benefits. Manual therapy involves applying varying degrees of pressure with the therapist’s hands on the treatment area or surrounding area of your body. Manual therapy and exercise have inherent physical risks associated with them. These risks may include, but are not limited to, muscle and soft tissue strains and soreness, joint strains and sprains, intravertebral disc injury, heart attacks or cardio-vascular complications, bone injuries, strokes and other complications known and unknown at this time.

By signing this form you are consenting to treatment by Seven Oaks Physical Therapy and Fitness Center Inc. You are acknowledging that you understand and are accepting the benefits and risks of physical therapy treatment. You understand that you may question your physical therapist at any time regarding your treatment and that you may decline any proposed treatment or stop any treatment at any time that is currently being utilized.

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Patient Signature   Date

PATIENT INFORMATION CONSENT

In the event we need medical information from your physician during the course of your treatment, please sign the medical information release below.

My signature authorizes my referring Doctor to provide Seven Oaks Physical Therapy and Fitness Center, Inc. with my personal medical information in order that my Physical Therapist may provide more appropriate treatment.

Patient Signature Date

I have read and fully understand Seven Oaks Physical Therapy and Fitness Center, Inc's Notice of Information Practices. I understand that Seven Oaks may use or disclose my personal health information for 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 for treatment, payment and administrative operations if I notify the practice. I also understand that Seven Oaks Physical Therapy and Fitness Center, Inc. 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 Seven Oaks Physical Therapy and Fitness Center, Inc'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 Signature Date

PRIVATE INSURANCE PATIENTS

While we attempt to assist you with your insurance, often times we are given incorrect information prior to claims processing. Therefore, it is the responsibility of the patient to know and understand the policies and benefits of their insurance plan and comply prior to starting treatment. This includes:

- Providing an up-to-date insurance card on file
- Copayment and deductible amounts and paying at the time of service
- To find out if the proposed facility for your procedure is contracted with your health plan
- Prior authorized procedures and current claim address

I understand that I am responsible to pay any deductibles and copayments at the time of service. I also agree to notify Seven Oaks Physical Therapy of any changes made to my insurance plan or benefits.

Signature Date

MEDICARE PATIENTS

MEDICARE "SIGNATURE ON FILE" REQUIREMENTS

I request that payments of authorized Medicare benefits can be made either to me or on my behalf to Seven Oaks Physical Therapy for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits of the benefits payable to related services.

I understand my signature request that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 form is completed, my signature authorizes releasing of the information to the insurer or to the agency shown. In Medicare assigned cases, the physician/supplier agrees to accept the charge determination of the Medicare carrier as the full charge. The patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature Date

ADVANCE BENEFICIARY NOTICE REGARDING MEDICARE

By my signature I acknowledge that I have not recently received any care from a Home Health Agency (nursing, social worker, physical therapy) or if I have, that I have been discharged from their care. Additionally, should I require Home Health Care services during the course of my treatment, I will advice Seven Oaks Physical Therapy. Medicare does not cover/pay for outpatient physical therapy if you are receiving any type of Home Health services.

Signature Date

EXPLANATION OF INSURANCE BENEFITS

Due to the amount of patients we see daily at our facility and the time it takes to directly contact an insurance company, we cannot give an immediate response regarding insurance benefits. It is ultimately the patient's responsibility to understand their insurance benefits. This includes in-network/out-of-network benefits, deductibles, copayments, number of visits allowed, treatments allowed, authorizations required. The information provided to us regarding your insurance is never a guarantee of payment. Also note that Seven Oaks will only bill a secondary insurance if we are a contracted provider.

The type of insurance benefits you have are between you, the policy holder, and your insurance company. If your insurance benefits are not what you think they are, it could result in significant out of pocket expenses that you did not expect. Do not hold Seven Oaks responsible for what your insurance company may or may not pay. If you have a large deductible that has not been met, or if you have a copayment for each visit, you will need to pay for services at the time of service.

If your Medicare Part B insurance coverage is current, not assigned to HMO/PPO or Home Health Service, it is not necessary for you to call Medicare for insurance information. All Medicare benefits are standardized, and Seven Oaks is Medicare certified facility. We do highly recommend Medicare patients call to verify benefits with their secondary insurance since some plans may not be "supplemental" to Medicare.

I understand that it is my responsibility to call and determine what my insurance plan benefits are for physical therapy at Seven Oaks. Should I have any additional questions, I may contact Seven Oaks business office.

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Patient Signature Date

SEVEN OAKS CANCELLATION POLICY

Reasonable notice is required or a **$50.00 fee** will be added to your account for each missed appointment. Your therapist and their assistant have this time reserved to treat you and if you do not show, this time is wasted.

Most medical offices require 24-hour cancellation notice to avoid a cancellation charge. Seven Oaks has significantly reduced this period to accommodate unforeseen events. Reasonable notice for a morning appointment is anytime prior 6:00PM the evening before. Reasonable notice for an afternoon appointment is no less than 6 hours prior to your appointment time.

Please accommodate and provide Seven Oaks time to fill a cancelled time with another patient who may be waiting for an appointment. We appreciate your cooperation.