SELECT THERAPY LOCATION

☐ **Highland & Industrial Center**
16645 Highland Rd # L
Baton Rouge, LA 70810
highland@dtphysicaltherapy.com

☐ **Downtown**
160 North 8th Street
Baton Rouge, LA 70802-5600
downtown@dtphysicaltherapy.com

☐ **Dutchtown**
13053 LA Hwy 73, Suite B
Geismar, LA 70734
dutchtown@dtphysicaltherapy.com

PATIENT INFORMATION

FIRST NAME: _____ TODAY'S DATE: ____/____/___
LAST NAME: _____ BIRTH DATE: ____/____/____
ADDRESS: _____ PATIENT'S SSN: ____/____/____
CITY _____ STATE _____ ZIP _____ PATIENT SEX: M F
HOME PHONE #: (___)_____ CELL PHONE #: (___)_____
EMAIL ADDRESS: _____
MARITAL STATUS: SINGLE ☐ MARRIED ☐ OTHER ☐
HOW DID YOU HEAR ABOUT US?
_____

EMPLOYMENT STATUS: EMPLOYED ☐ F/T STUDENT ☐ P/T STUDENT _____ OTHER_____
OCCUPATION: _____ EMPLOYMENT RELATED ACCIDENT: Y N
DATE INJURED: _____/_____/_____ AUTOMOBILE RELATED ACCIDENT: Y N
EMPLOYER NAME: _____ PHONE #: (___)_____
ADDRESS: _____
CITY _____ STATE _____ ZIP _____

PRIMARY CARE PHYSICIAN: _____REFERRING PHYSICIAN: _____
IN CASE OF EMERGENCY: _____ PHONE #: (___) _____

PRIMARY INSURANCE: _____ INSURED'S NAME: _____
ADDRESS: _____ INSURED'S DOB: _____/_____/_____
CITY_____ STATE _____ ZIP _____ INSURED'S SSN: _____/_____/_____
PHONE #: (___) _____RELATION TO INSURED: _____
INSURED ID #: _____ GROUP #: _____

SECONDARY INSURANCE: _____ INSURED'S NAME: _____
ADDRESS: _____INSURED'S DOB: _____/_____/_____
CITY _____ STATE _____ ZIP _____ INSURED'S SSN: _____ /_____/_____
PHONE #: (___) _____RELATION TO INSURED: _____
INSURED ID #: _____GROUP #: _____

I HEREBY CERTIFY THAT ALL INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE, AND I AM RESPONSIBLE FOR ALL CHARGES INCURRED FOR THESE SERVICES. I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION

NECESSARY TO PROCESS MY CLAIM AND AUTHORIZE MY INSURANCE COMPANY TO PAY DOWNTOWN PHYSICAL THERAPY & INDUSTRIAL CENTER DIRECTLY FOR SERVICES RENDERED.

PATIENT'S SIGNATURE: _____ **DATE**: _____
(GUARDIAN OF)

MEDICAL HISTORY

PATIENT NAME: _____ DATE: _____
REFERRING PHYSICIAN: _____ FAMILY PHYSICIAN: _____
HOW WERE YOU INJURED? _____
DATE OF INJURY/ONSET: _____ STATE INJURY OCCURRED: _____
DATE OF SURGERY: _____WHAT BODY PART IS INJURED? _____
HEIGHT: _____ WEIGHT: _____

Family Medical History (Do you have a family history of any of the following illness?)

Illness	Yes	No	Illness	Yes	No
Cancer	☐	☐	Rheumatoid Arthritis	☐	☐
Heart Attack/Disease	☐	☐	Degenerative Arthritis	☐	☐
High Blood Pressure	☐	☐	Thyroid Disease	☐	☐
Diabetes	☐	☐	Immune Disorders	☐	☐

Past Surgical History

Year	Name of Operation	Type of Anesthetic (general, regional, local)	Complications

Medications

Drug	Dosage	Drug	Dosage
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

PATIENT/GUARDIAN SIGNATURE: _____ **DATE**: _____

THERAPIST'S SIGNATURE: _____ **DATE**: _____

Place an "X" in either the Yes or No column for the following conditions:

	Yes	No		Yes	No		Yes	No
Constitutional Symptoms			**Gastrointestinal**			**Neurological**		
Recent Weight Change			Loss of Appetite			Frequent headaches		
Fever			Nausea or vomiting			Lightheaded or dizzy		
Unexplained sweating			Frequent diarrhea			Seizures		
Eyes			Constipation			Numbness or tingling		
Wear glasses or contacts			Rectal Bleeding or blood in stool			Tremors		
Blurred or double vision			Black tarry stools			Paralysis		
Glaucoma			Regular abdominal pain or heartburn			Stroke		
ENT			Stomach Ulcers			**Psychiatric**		
Hearing loss			**Genitourinary**			Memory loss or confusion		
Regular nose or gum bleeding			Frequent urination			Anxiety		
Sore throat			Burning or painful urination			Depression		
Swollen glands in neck			Blood in urine			Insomnia		
Cardiovascular			Incontinence or dribbling			**Endocrine**		
Irregular heart beats			Kidney disease			Thyroid disease		
Shortness of breath			Liver disease			Glandular or Hormone Problem		
Swelling in feet, ankles, and hands			Female: # of pregnancies			Excessive thirst or urination		
Fainting spells			Female: # of miscarriages			Heat or cold intolerance		
Elevated cholesterol			Female Only: are you pregnant?			Changes in hair or nails		
Heart attack/disease			**Musculoskeletal**			**Hematology**		
Chest pain or angina			Joint pain			Hepatitis		
Pacemaker			Joint stiffness and swelling			Bruising tendency		
Respiratory			Morning stiffness			Blood Clots		
Chronic or frequent coughing			Gout			Bleeding tendency		
Spitting up blood			Osteoporosis			AIDS or HIV Infection		
Regular shortness of breath			Accidents/Broken bones			Anemia		
Emphysema			Difficulty walking			Need for past transfusion		
Regular wheezing			Muscle cramping			**Patient:**		
			Integumentary			Height:_____		
			Rash or itching			Weight:_____		
			Changes in skin color					
			Varicose veins					

Patient/Guardian Signature: _____ **Date**: _____

Therapist's Signature: _____ **Date**: _____

CONSENT FOR RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize Downtown Physical Therapy & Industrial Center to release information concerning my treatment, including the reproduction of my medical records, for each third-party insurer from whom I may seek payment or reimbursement for expenses related to my treatment. I further assign all benefits and authorize payments directly to Downtown Physical Therapy & Industrial Center for the insurance benefits to which I am entitled and which are otherwise payable to me, but not to exceed Downtown Physical Therapy & Industrial Center's regular charges for services rendered during this period of treatment. I understand, unless otherwise specifically provided by contract that I am and remain financially responsible to Downtown Physical Therapy & Industrial Center until my account is paid in full, whether or not covered by this authorization.

CONSENT FOR TREATMENT

I, _____, hereby allow Downtown Physical Therapy & Industrial Center to render treatment to me based upon my specific complaints and the referral from my physician. I understand that my treatment from Downtown Physical Therapy & Industrial Center is based upon findings from my medical doctor and release Downtown Physical Therapy & Industrial Center from responsibility for resulting illness, ill effect, or reaction from treatment ordered by my physician.

I have read all the above and certify that I understand its content.

Signature of patient: _____ **Date**: _____
(Parent or Guardian if patient is under 18 years of age)

CONTACT PERSON

The name and address of the person you can contact for further information concerning our Privacy Practices is:

SCOTT LARSON
Downtown Physical Therapy & Industrial Center
16645 Highland Rd. Suite L
Baton Rouge, La 70801

Effective Date
This Notice is effective on or after **OCTOBER 15, 2000**

SIGNATURES

I have reviewed this consent form and give my permission to **Downtown Physical Therapy & Industrial Center** to use and disclose my health information in accordance with it.

_____
Name of Patient (Print)

_____ _____
Signature of Patient or Guardian **Date**

_____
Relationship of Patient Representative to Patient

OUR FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy which we require you read and sign prior to any treatment. Please let us know if you have any questions or concerns. Our office staff will be happy to provide you with more information regarding payment options.

PAYMENT OPTIONS
Payment of co-pays and/or any unmet deductible is due at time of service. If you have a large deductible we can work a payment plan out for you. We accept cash, checks, or most major credit cards.

REGARDING INSURANCE
We do accept assignment of insurance benefits and will be happy to file claims on your behalf. The balance is your responsibility regardless of whether your insurance company pays or not. We cannot bill your insurance company unless you give us your COMPLETE AND CURRENT insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. It is your responsibility to insure they live up to the terms of that contract. If the insurance company requests information from you, it is your responsibility to send it to them. If it is not received, your claims will be denied and you will be responsible for the amount of your bill. If the insurance company has not made full payment within 120 days we will bill you the entire amount that is owed. If you prefer to file insurance claims yourself, you may pay your account in full using the above methods. We will assist you by providing all appropriate information your insurance company will require.

Please be aware that some of the services provided may not be considered necessary under the terms of your particular plan. Please be assured that our practice will provide only those services which your doctor and physical therapist determine are necessary for you.

PATIENT PAYMENT GUARANTEE
Our practice is committed to providing the best treatment for our patients and our charges reflect what is usual and customary for our area. Please remember that you are responsible for all charges and expenses of Downtown Physical Therapy & Industrial Center of every kind and description, for services, facilities and any other thing supplied or furnished the patient. If the account goes to our outside collection agency, the patient agrees to pay any additional costs in obtaining the amount due.

I, _____, have read and understand the above financial policy and I agree to abide by this policy.

_____ _____
Signature of Patient or Guardian **Date**