PANTHER PATIENT INFORMATION

PANTHER PHYSICAL THERAPY & SPORTS PERFORMANCE

DEMOGRAPHIC INFORMATION

Patient Full Name (F, MI, L): _____ SSN: _____

Name Preference: _____ Date Injured: _____ Date of Surgery _____

Address: _____ Date of Birth: _____ Age: _____ Sex: M F

City: _____ State: _____ Zip: _____ Home #_____ Cell #_____

Email Address: _____ How did you hear about us? _____

Referring Dr.: _____ Injury/Diagnosis: _____

Primary Care Physician: _____ PCP Phone Number: _____

Employer: _____ Employer Address: _____

Employer Phone #_____ City: _____ State: _____ Zip: _____

Guarantor Name: _____ Date of Birth: _____

Relationship to Patient: _____ Phone #: _____

Address if different: _____ City: _____ State: _____ Zip: _____

INSURANCE INFORMATION

For Private, Medicare, or Government Providers: Please present Insurance ID card to front desk.

*If you are being seen for an injury related to **work comp or an auto accident,** please give the name of the insurance carrier responsible.*

Workers Comp: Y N Auto: Y N

Insurance Company: _____

Adjuster Name: _____ Phone # _____

Claim #: _____

MEDICAL HISTORY

Height: _____ Weight: _____

Do you have, or have you ever had any of the following?

Heart problems/pacemaker	Y N	History of falls	Y N
Lung/breathing problems	Y N	Arthritis	Y N
Diabetes	Y N	Osteoporosis/Osteopenia	Y N
Cancer	Y N	Dizziness	Y N
High BP	Y N	Fainting	Y N
Asthma	Y N	Seizures	Y N
Blood Disorders	Y N	Unexplained weight loss	Y N

Any other Medical History? _____

_____

Do you currently have or have you had any of the following symptoms related to your injury?

Arm/Leg Swelling	Y N	Joint/Muscle Swelling	Y N	Problems Sleeping	Y N
Constipation/Diarrhea	Y N	Nausea/Vomiting	Y N	Problems Urinating	Y N
Fever/Chills/Sweats	Y N	Numbness/Tingling	Y N	Unusual Fatigue	Y N

If Yes to any of the above, please explain: _____

_____

_____

Any previous surgical procedures and or significant injuries? _____

_____

_____

Medications currently taking (prescription, over the counter, pills, injections, patches, vitamins, herbs?

_____

_____

Allergies (medications, food intolerances, latex, etc.?_____

_____

_____

Do you participate in any sports, exercise programs or activities on a regular basis? _____

_____

Anything else you want us to know? _____

EMERGENCY CONTACT: Name: _____ Relationship: _____ Phone #: _____

CONSENT TO TREAT AND HIPAA ACKNOWLEDGEMENT

The patient has the right to informed participation in decisions involving his/her health care. This shall be based on clear, concise explanation of his/her condition and of all proposed treatment procedures. All possible risks and/or side effects, as well as the probability of success with such procedures shall be disclosed to the patient by his/her attending physical therapist. The patient shall not be subjected to any procedure without his/her voluntary, competent and understanding consent or consent of his/her legally authorized representative. Where medically significant alternatives for care or treatment exist, the patient shall be so informed. I have read and understand the terms outlined above and consent to all necessary treatment as determined by Panther Physical Therapy.

I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. I will be given a copy of the privacy practices upon request.

Patient Name: _____ Signature/Guardian: _____

Date: _____

CANCELLATION POLICY/NO SHOW POLICY

Thank you for choosing Panther Physical Therapy as your physical therapy provider. We are sincerely dedicated in assisting you meet your therapy goals. In order to do this, it is important that you attend all scheduled therapy appointments. Consistent attendance allows you and your therapist to progress your treatment program which will result in **quicker recovery and better outcomes.**

We realize that there are times when unforeseen circumstances make it impossible to attend your scheduled appointment. If this happens, please give us as much notice as possible so we can reschedule your appointment and open that slot for another client.
If you are calling after hours you may leave a message at **303-979-5511**.

24 HOUR NOTICE

In order to enforce this policy, you will be charged $75.00 for an appointment cancelled without 24-hour notice. (If that appointment slot gets filled by another patient we will waive the charge.)

NO CALL/ NO SHOW

If you do ***not show up*** or ***call to cancel*** an appointment you will be charged $95.00 payable at your next visit.

Canceling appointments without 24-hour notice and no shows more than ***3 times*** will unfortunately limit your ability to schedule advanced appointments and will result in ***same day scheduling***.

We want to make your physical therapy experience as beneficial as possible and your commitment is a very important part of this. If you know you are going to have a difficult making your appointments, please discuss this with your therapist.
Thank you

Patient/Parent/Legal Guardian Signature_____

Print Name_____ Date: _____

FINANCIAL RESPOSIBILITY

1. According to your insurance plan, ***you are responsible for any and all co-payments, deductibles, and coinsurances***. The amount of co-payment varies with different plans. You are responsible for knowing the co-payment amount. ***All charges not covered by your insurance company are your responsibility.***
2. ***Co-payments are due at the time of service***, unless other arrangements have been made. ***Deductibles and coinsurance are your responsibility*** and will be billed to you by our office, although ***we strongly recommend paying $80.00 per visit for high-deductible plans.***
3. Self-pay patients are expected ***to pay for services in FULL*** at the time of the visit.
4. Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. ***Your payment is due within 10 business days of your receipt of your bill.***
5. If previous arrangements have not been made with our finance office, ***any balance outstanding longer than 90 days will be forwarded to a collection agency.***
6. We accept cash, check, credit card (Visa, MasterCard, American Express, and Discover), and debit card.
7. A $25.00 fee will be charged for any checks returned with insufficient funds.

   Initial: _____

Please call if you have any questions about your bill. Most problems can be settled quickly and easily, and your call will prevent any misunderstandings. If you are having trouble paying your bill, please discuss the situation with us. Satisfactory arrangements can almost always be made. Financial considerations should never prevent you from receiving the care needed.

I have read the above Financial Policy, I have understood it, and I agree to it. I have also received a copy of this Financial Policy, if requested.
Thank you

Patient/Parent/Legal Guardian Signature_____

Print Name_____ Date: _____

"RUN MY CARD!"- KEEP IT WITH US TO MAKE FASTER PAYMENTS FOR YOU OR YOUR FAMILY

OPTIONAL CREDIT CARD ON FILE (SECURED)

You are giving PANTHER PHYSICAL THERAPY permission to automatically charge your credit card on file for your Co-Pay, Deductible or Co-Insurance or any other patient(s) balances you have listed on this form at time of service.

I authorize Panther Physical Therapy to charge co-pays and outstanding balances on my account to the following credit card:

Visa_____ MasterCard_____ Discover_____

Credit Card Holder's Name: _____ (Please Print)

Credit Card # _____

Expiration Date: _____ Security Code: _____

Co-pays: Co-pays are due at time of the office visit.

Outstanding Balance: If your insurance provider has paid their portion of your bill or any other patient(s) you have listed on this form and there is still an outstanding balance owed, Panther Physical Therapy will notify you via mail. If the balance owed is not paid within 30 days, Panther Physical Therapy will charge the balance to your credit card. A copy of the charge will be mailed to you. This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment.

This credit card on file is to be used for the following patient(s), please print name(s) below: (expires after 1 year)

Patient Full Name: _____ DOB: ____ / ____ / _____

Patient Full Name: _____ DOB: ____ / ____ / _____

Patient Full Name: _____ DOB: ____ / ____ / _____

Multiple Users: This card will only be authorized for the use of the credit card holder, his/her minor(s), or any person(s) listed above. This agreement will expire for multiple users on an annual basis. If continued authorization is requested, another credit card agreement can be issued or a manager can verbally authorize and document the extension of an agreement.

Signature: _____Date: _____