Patient Information

First Name: _____ Last Name: _____

Parent/Guardian: _____ Today's Date: _____

Date of Birth: _____ Gender: M/F SSN: _____

Preferred method of communication: ☐ Phone ☐ Email

Email: _____@_____. com

Home Phone: _(_____)_____ Cell Phone: _(_____)_____

Work Phone: _(____)_____ext._____

Emergency Contact: _____ Phone: (_____)_____

Mailing

Address Line 1: _____

Address Line 2: _____

City: _____ State: _____

Zip Code: _____

Employer Name and Address: _____

Occupation: _____

Health Insurance Information

Primary Carrier Name: _____

Address and Phone: _____

ID #: _____ Group #: _____

Secondary Carrier Name: _____

Address and Phone: _____

ID #: _____ Group #: _____

HIPAA COMPLIANCE PRIVACY & CONFIDENTIALITY

(This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully.)

Although your health record is the physical property of the health care facility, the information in your records belongs to you. You have the following rights:

- You may request that the health care facility NOT use or disclose your health information for a particular related treatment, payment, the facility's general health care operations, and/or to a particular family member, other relative or close friend. Although we will consider your request, please be aware we are under no obligation to accept it or to abide by it. For more information about this right, see code 45 of Federal Regulations (C.F.R.) 164.522(a). The facility may contact you to provide appointment reminders. You have the right to receive confidential communications of your protected health information. As a caveat please understand that communications between staff and patients during therapeutic exercises may be compromised given the physical plant.
- If you are dissatisfied with the manner which or the location where you are receiving communications from us that are related to your health information, you may request that we provide you with such information by alternative means or at alternative locations. Such a request must be made in writing and submitted to the health care facility's Privacy Officer. We will attempt to accommodate all reasonable requests. For more information about this right, see 24 C.F.R. 164.522(b).
- You may request to inspect and /or obtain copies of health information about you, which will be provided to you in the periods established by law. If you request copies, the health care facility will charge you a reasonable fee. For more information, see 45 C.F.R. 164.524. Upon written or verbal request of a patient, a release of records form is to be provided to the patient for his or her signature; this form should be provided to the patient as expeditiously as possible; after receipt of the executed records release, a copy of the requested patient records is to be provided to the patient in the manner designated by the patient; such record copies are to be provided within 14 days of receipt of the executed release and in no case, later than 30 days after receipt of the release.
- If you believe that any health information in your record is incorrect or if you believe that important information is missing, you may request that we correct the existing information or add the missing information. Such requests must be made in writing and must provide a reason to support the amendment. For more information, see 45 C.F.R. 164.526
- You may request that we provide you with a written accounting of all disclosures made by us during the time for which you request. Such requests must be made in writing. Accounting will not apply to the following: disclosures made for reasons of treatments, payment or health care operations, disclosures made to you or your legal representative or any other individual involved in your care: disclosures to correctional institutions or law enforcement officials; and disclosures for national security purposes. You will not be charged for your first account requests, any requests thereafter will be charged at a reasonable fee. For more information, see 164.524. No other disclosures or uses of your medial records will be made other than stated in this document without your written authorization, see 164.520 sub (b) sub (ii) (E).
- You have a right to obtain a paper copy of your Notice of Information Practices upon request.
- You may revoke an authorization to use or disclose health information, except to the extent that action has already been taken. Such a request must be made in writing.

If you have any questions and would like additional information, you may contact the health care facility's Privacy Officer.

If you believe that your privacy rights have been violated, you may file a complaint wit the health care facility. These complaints must be filed in writing on a form provided by the health care facility. The form can be obtained from the Privacy Officer and returned to the Privacy Officer. You may also file a complaint with the secretary of the federal department of Health and Human Services. There will be no retaliation for filing a complaint. There will be no changes in this privacy practice without a written notice provided to you setting forth any change.

HIPAA Compliance Officer: Jessica Schnell, DPT
(340) 514.2376 Saint John Physical Therapy

Signature: _____ Date: _____

St. John Physical Therapy

Authorization/Consent/Financial Policy

Authorization to Release Medical Record Information

St. John Physical Therapy is herby authorized to disclose all or any part of medical record of the patient named in the registration to such insurance companies or agencies as may be concerned with the payment of professional and/or facility costs of the patient named on this registration. The authorization is effective for three years from the date of service and may be revoked with written notification.

Consent For Medical Treatment

The undersigned hereby consents to any therapy, treatment, or facility service rendered to the patient under the general and special instructions of the therapist assigned to care for me. I also acknowledge that no guarantee or

warranty has been made by said therapist of St. John Physical Therapy as to the results of any treatment given or preformed.

Medicare

St. John Physical Therapy accepts Medicare assignment. This means that we will accept the Medicare approved amount as payment in full for our services. We will bill Medicare and your supplemental insurance company. The Health Care Financing Administration (HCFA) of the United States Government has issued a warning that providers who waive the co-insurance charge or annual deductible for Medicare are subject to prosecution for fraud. We, therefore, must collect the deductible and the remaining 20%. If your supplemental insurance company does not pay or if your Medicare deductible has not been met, you will receive a statement from us indicating the amount you owe. Dressing and supplies will not be covered by Managed Care Organizations or Medicare, therefore, you will be financially responsible for these items at the time of service.

Workers' Compensation

If you are a patient with a valid Workers' Compensation claim, we will bill your employer's insurance carrier for reimbursement on all treatment rendered. If you have reached Maximum Medical improvement as deemed by the insurance carrier, you will be responsible for co-payment for each visit.

Usual And Customary Rates

Our Practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. **St. John PT request a 12 hour cancelation notice prior to your appointment , Other wise a $25.00 Fee will the patients responsibly**.

Regarding Insurance

Billing insurance is done as a courtesy to the patient and does not dismiss the patient's responsibility for payment in full. Some companies will pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is the patient's ultimate responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance company. Regarding insurance plans where we are a participating provider all co-pays and deductibles are due prior to treatment. Payment sent to the patient must be forwarded to the provider upon receipt. **By my signature below, I recognize, understand and accept that I am ultimately financially responsible for any and all charges for services rendered by including, but not limited to, any service or fees not covered or denied by my insurance company.** Additionally, I agree to pay all charges associated with the cost of collection. If my account becomes delinquent, including reasonable attorney's fees, court costs, finance charges and the legal rate of interest on the account until paid in full.

Medical Emergencies

It is our policy to call 911 in case of medical emergencies

I certify that I have read and understand fully the above information.

Signature of patient or Responsible Party	Print Name	Date
Signature of Parent or Guardian	Print Name	

			MEDICAL HISTORY					
	Y	N		Y	N		Y	N
High/Low Blood Pressure			Parkinson's Disease			Macular Degeneration		
Coronary Artery Disease			Asthma			Osteoarthritis		
Abdominal Aortic Aneurysm			Shortness of Breath			Rheumatoid Arthritis		
Peripheral Vascular Disease			Emphysema			Fibromyalgia		
Heart Attack			Cancer			Psoriasis/Eczema		
Arrhythmia			Kidney Disease			Lupus		
Seizure Disorder			Urinary Tract/Disease			HIV positive/AIDS		
Stroke (CVA or TIA)			Prostate Disease			Osteoporosis/ Osteopenia		
Neuropathy			GI Problems/Disease			Fractures		
Diabetes			Ulcer			Spinal Stenosis		
Hypoglycemia			Diverticulitis			Degenerative Disc Disease		
Hypothyroidism/Hyperthyroidism			Liver Disease			Disc Herniation/Bulge		
Vertigo			Gall Bladder Disease			Difficulty hearing?		
Balance Problems – Inner Ear			Headaches (Tension/Migraine)			Difficulty seeing?		
Balance Problems – Other			Glaucoma			Other:		

SURGICAL HISTORY								
	Y	DATE		Y	DATE		Y	DATE R/L
Tonsillectomy			Angioplasty			Cervical Surgery		
Appendectomy			Pacemaker			Lumbar Surgery		
D & C			Thyroid			Shoulder Surgery		
Hysterectomy			Gall Bladder			Elbow Surgery		
C-Section			Liver			Wrist Surgery		
Mastectomy R/L			Kidney			Hand Surgery		
Breast Reconstruction R/L			Gastrointestinal			Hip Surgery		
Breast Augmentation R/L			Bariatric Bypass			Knee Surgery		
Prostate			Cataract R/L			Ankle Surgery		
Cardiac Bypass			Eye – Other R/L			Foot Surgery		
Cardiac Catheter					Other:			

ACTIVITIES/SOCIAL							
	Y	N	OCC		Y	N	OCC
Stress - Home				Exercise Routine			
Stress – Work				Please specify:			
Heavy Lifting				Sports			
Do you smoke?				Please specify:			
Do you drink?							

Allergies/Medicine:_____ Allergies/Other:_____

_____ _____

Signature *Date*

Saint John
Physical Therapy
History of Current Episode

NAME: _____ AGE: _____
DATE OF BIRTH: _____ TODAY'S DATE _____
NATURE OF PROBLEM: _____
MECHANISM OF INJURY: _____
IS THIS EPISODE DUE TO AN AUTOMOBILE ACCIDENT? _____

HAVE YOU HAD MORE THAN 2 FALLS IN THE LAST YEAR? YES/NO

CURRENT PAIN LEVEL:

PLEASE CIRCLE: 0 1 2 3 4 5 6 7 8 9 10 (0 = no pain/ 10 meaning intense pain)

Where did the pain start? _____ Where did the pain spread? _____
Does the pain prevent you from sleeping/awaken you? _____
Do you have any numbness/tingling? _____
Do you have difficulty sitting/ standing/ walking? _____
_____

Is your pain better/ worse/ same throughout the day? ____Morning: ____ Mid-Day: ____ Night: ____

PLEASE LIST YOUR CURRENT MEDICATIONS/DRUG NAME/DOSAGE/FREQUENCY/ROUTE

1.)
2.)
(IF MORE PLEASE COMPLETE ON BACK OF THIS PAGE)

Referring Physician: _____ Phone: _____
Local Physician: _____ Phone: _____
WHO REFERRED YOU TO ST. JOHN THERAPY (IF NOT A PHYSICIAN) _____
Have you previously received physical therapy in the current calendar year? YES/NO
If yes, approximately how long? _____
Are you currently receiving any medical care at home? YES/NO

*****Medicare will not cover simultaneous home health care and outpatient physical therapy****

Are you currently receiving treatment for same symptoms by another health care provider? YES/NO
Is there litigation associated with this episode? YES/NO
Attorney: _____ Phone/ Fax: _____
What are your goals for therapy:
_____
_____

Signature: _____ Date: _____