

21st Century Rehab, P.C.

Altoona

Carlisle

Indianola Physical Therapy

Grimes

Madrid

PATIENT INFORMATION FORM

Please print and complete ALL items. If an item doesn't apply, put N/A

Patient Legal Name: _____ Age: _____
last first middle

Address: _____
street city state zip

Email: _____

Home Phone: _____ Work Phone: _____ Marital Status: _____

Social Security #: _____ Sex: _____ Date of Birth: _____

Employer: _____ Full time student: yes ___ no ___

Spouse's Name: _____ SS#: _____ Date of Birth: _____

Spouse's Employer: _____ Phone: _____

Referring Doctor: _____ Phone: _____ Next Dr. appt. _____

Primary Care Physician: _____ Phone: _____

Person to notify in case of emergency OUTSIDE of household:

Name: _____ Home Phone: _____ Work Phone: _____

Address: _____
street city state zip

Injury History

Have you been treated here or by another physical therapist previously? Yes ___ No ___

If yes, where? _____ When? _____

Was it for the same condition? Yes ___ No ___ If not, please specify: _____

Date of onset of current episode of symptoms/injuries/illness: _____

Place of injury: Home ___ School ___ Work ___ Auto ___ Other _____

Parts of BODY being treated for this injury: _____

Where did you hear about 21st Century Rehab?

Doctor Referral Newspaper Radio Friend/Family Other _____

Please continue on next page.

Responsibility Information

Who will be primarily responsible for the bill? _____

I will be paying my share of financial responsibility by: Cash ____ Check ____ Credit Card N/a

PRIMARY Insurance Company: _____ Phone #: _____

Insurance Company address: _____

Policy Holder's *Full* Name: _____

Policy Holder's ID #: _____ Date of Birth: _____

Relationship to Policy Holder _____

Address: _____

Policy Holder's Employer: _____ Employer's Phone: _____

Is there Secondary Insurance? Yes ____ No ____

Name of Secondary Insurance Company: _____

Insurance Company Address: _____

Policy Holder's *Full* name: _____

Policy Holder's ID#: _____ Date of Birth: _____

Relationship to Policy Holder: _____

Policy Holder's Employer: _____ Employer's Phone _____

ARE YOU CURRENTLY or HAVE YOU RECENTLY RECEIVED ANY HOMEHEALTH CARE?

Yes ____ No ____ Dates of Service: _____

Name of Agency: _____ Phone Number: _____

IS THIS A WORKER'S COMPENSATION CLAIM? Yes ____ No ____ Date of Injury: _____

Company: _____ Address: _____

Phone Number: _____ Claim #: _____ Contact Person: _____

IS THIS AN ACCIDENT CASE? Yes ____ No ____ VEHICLE ____ OTHER _____

Insurance Company to Bill: _____

Address: _____

Phone #: _____ Case #: _____

Adjuster Name: _____

Is there an attorney involved in your case? Yes ____ No ____

Attorney's Name: _____ Phone: _____

Address: _____

21st Century Rehab, P.C.

Consent to Medical Care

I consent to the therapy rendered to me(or the person for whom I am legally responsible) that is determined to be necessary by the therapist and/or physician.

Financial Agreement

I agree to pay for the services rendered to me (or the person for whom I am legally responsible, either directly or through my insurance or third party payer(s). If through a third party payer, I hereby assign all the benefits payable for this care, to the provider. I also agree to pay directly for any services not covered by my third party payer(s). Our office requires a 24-hour notice for cancellation of appointments; you can call and leave a message on the answering machine if needed. We realize conflicts with work, other activities, or unexpected illness may require you to call and reschedule; however, there will be a \$25.00 charge for a missed appointment without notification to the office. For liability cases, where another party is responsible, you need to provide us with all the billing information. If you have an attorney, please provide this information on the registration form. It is this office's policy that a letter of protection must be received from your attorney within the first 2 weeks of your treatment. Without this letter, you become responsible for the account in full.

Release of Medical Information

I hereby authorize the provider to release to my insurance company (companies) or third party payer(s) all medical information needed to substantiate payment for the care to me (or the person for whom I am legally responsible) and permit representatives to examine and make copies of records relating to such care and treatment.

ACKNOWLEDGMENT OF RECEIPT OF PROVIDER'S NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge that I have received a copy of 21st Century Rehab, P. C.'s Notice of Privacy Practices which summarizes the ways my identifiable health information may be used and disclosed by Provider and states my rights with respect to my medical information. I understand Provider has the right to revise these information practices and to amend the Notice of Privacy Practices. I have been informed that in the event Provider revises its information practices, a revised Notice will be posted at 21st Century Rehab Clinics and that I may obtain a current Notice of Privacy Practices at any time from Jason Horras at 515-382-3366.

SIGNATURE: _____ DATE: _____

Signature for Minor (under 18 years of age): _____

RECEPTIONIST INITIALS _____

For Office Use Only: Date of Birth: _____ Onset Date: _____

Therapist: _____ Referral Date: _____

Diagnosis _____ ICD-9 _____
(can not use V67.0 for diagnosis)

Physician _____ Physician UPIN _____

Physician Address _____
street city state zip