PHYSICAL THERAPY SERVICES of ROCHESTER

PATIENT INFORMATION FORM

Name: First _____ MI _____ Last _____

Address: _____
Street City State Zip

Home phone: (____)_____-_____ Cell phone: (____)_____-_____

Email address: _____ Age: ____ DOB: ____/____/_____

Employer _____ Occupation: _____

Emergency Contact: _____ Phone #: (____)_____-_____

Referring Physician: _____ Primary Care Physician: _____

Reason for therapy: _____ Date of onset/injury/surgery _____

Is this a work-related injury? ☐Yes ☐No If yes, when? _____

Have you seen a physical therapist this year? ☐Yes ☐No If yes, how many visits this year? _____

Are you seeing a chiropractor? ☐Yes ☐No If yes, how many visits this year? _____

For what? _____

May we obtain relevant x-ray/MRI/CT scan/reports? ☐Yes ☐ No

How did you hear about Physical Therapy services of Rochester? ☐Doctor ☐Friend/Family ☐Other

If other, please specify: _____

*Please check **ALL** that apply to your medical history:*

Pregnant? ☐ Yes ☐ No ☐Cancer: _____

☐ High Blood Pressure ☐Joint Replacement:_____

☐Cardiac Condition ☐Neurologic condition: (type)_____

☐Osteoporosis ☐Diabetes: _____

☐Pacemaker ☐Accident/Trauma: (date)_____

If further explanation required on any of the above, please explain: _____

Do you presently take medication? ☐Yes ☐No If yes, please attach list or write on reverse.

Signature: _____ Date: _____
(Patient/Guardian)

Revised 11/2020

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Medication/Supplement/Vitamin Name:	Dose:	Frequency:	Diagnosis Taken For:
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Signature: _____ Date: _____
(Patient/Guardian)

PHYSICAL THERAPY SERVICES of ROCHESTER

540 White Spruce Blvd, Rochester, NY 14623 www.ptsrochester.com --- p: (585)427-7190 f: (585)427-2287

Patient Financial Policy and Privacy Rights

Policies and Procedures

Payment is due in full at the time of service. The patient/ guarantor are financially responsible for any fees associated with the visit. This includes any medical billing and/ or the clinic's policy in regards to cancellations and no shows. Patients will be charged a $50 fee for a no show/ cancellation within 24 hours of their scheduled appointment.

Any unpaid balances longer than 90 days, will be sent to a collections agency. At that point, the collections agency has the right to charge additional fees with the balance that is associated with the collection practices.

Patient Responsibility

I understand and agree that I am financially responsible for all charges for any and all services rendered. This includes any medical service or visit that is ordered by my doctor or completed by my Physical Therapist.

I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance within my plans contractual amount.

I understand and agree that it is my responsibility to know if my insurance has my deductible, copayment, co-insurance, out of network, prior authorization requirements or any other type of benefit limitation for the services I receive and I agree to make payment in full at the time of service. I understand that I can pay my balance in the forms of tender the clinic accepts and that there will be a $30 returned check fee.

I understand and agree that it is my responsibility to know if my insurance requires a referral from my primary care physician and that it is up to me to obtain the referral. I understand that without a referral, my insurance has the right to refuse payment for my services and that I will be financially responsible for all services rendered.

I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or terminated at any time of service, I agree that I am financially responsible for the balance in full.

If I am a Medicare patient, I understand that I need to provide the office both my Medicare ID card and my secondary ID card. If the office does not have the proper information for my secondary insurance, the secondary will not be billed. It will be my responsibility to pay the balance and then file a claim with the secondary for reimbursement.

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HIPAA Policy

Patients are entitled to:

- A clear and written explanation of how we may use and disclose patient information
- To request restrictions on certain uses and disclosures
- To request and obtain copies of your medical and pertinent financial records (at $.75 per page) and request changes if appropriate
- To receive accounting of how your health information was used
- Confidential communications
- To file a complaint if you feel that your privacy rights have been violated without retaliation or retribution

To receive more information on our privacy policies or to file a complaint, you may contact our privacy officer in writing at 540 White Spruce Blvd, Rochester, NU 14623 or by calling 585-427-7190 Option 3.

I give permission to communicate my private healthcare information to: (**Please note: These are not Providers/ Medical Professionals**)

_____ _____

Name Relationship

_____ _____

Name Relationship

_____ _____

Name Relationship

By signing this form, I consent to the use and disclosure of protected health information about me for treatment, payment and health care operations, and/or such required by law. I agree to Physical Therapy Services of Rochester's financial policy and understand my role in the payment of services rendered.

_____ _____ _____

Printed Patient Name (and Guardian if Applicable) **Signature** **Date**

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