



# LAFAYETTE PHYSICAL THERAPY, INC.

## Patient Information

Last Name <small>(Legal Names Please)</small>	First Name	MI	Sex M F	Marital Status
Home Phone Cell/Alternate	SSN	DOB		AGE
Address (No P.O. boxes please)	City	State		Zip
Employer	Occupation	Work Phone		
Employer Address	City	State		Zip
Guarantor Name	Guarantor Employer	DOB	Phone	
Emergency Contact Person	Relation	Phone		
Referring Doctor	How did you hear about us? <input type="checkbox"/> Doctor <input type="checkbox"/> I am returning <input type="checkbox"/> Website <input type="checkbox"/> Internet Search <input type="checkbox"/> Friend/Family <input type="checkbox"/> Other: _____			
Automated Appt. Reminders: <b>Please select one phone number &amp;/or e-mail to receive appt. reminder notifications on</b> <input type="checkbox"/> Home <input type="checkbox"/> Cell/Alternate <input type="checkbox"/> Work <input type="checkbox"/> Email: _____ <input type="checkbox"/> No reminder				
Would you like to receive our e-mail newsletter – sent approximately 2 times per year? <input type="checkbox"/> Yes <input type="checkbox"/> No				

FOR OFFICE USE ONLY: Our front desk will fill out this portion upon your arrival

**Insurance: The following benefits were quoted to us by your insurance company. This is not a guarantee of payment by your insurance. You are responsible for knowing your benefits.**

- \_\_\_\_\_  Patient is eligible for benefits: Effective Date: \_\_\_\_\_ to \_\_\_\_\_
- Prior authorization is required  Month to month coverage
- Coverage is based on medical necessity  Rx required

**Benefits Information:**

\$ \_\_\_\_\_ Max \$ Per year, \$ \_\_\_\_\_ remaining

\_\_\_\_\_ Max visits per year, \_\_\_\_\_ visits used, \_\_\_\_\_ remaining

\_\_\_\_\_ % Insurance pays, \_\_\_\_\_ % patient co-insurance, we will collect \$ \_\_\_\_\_ per visit\* ↴

\$ \_\_\_\_\_ Total deductible, \$ \_\_\_\_\_ deductible met, collect \$ \_\_\_\_\_ per visit toward deductible\* ↴

\$ \_\_\_\_\_ Out of pocket, \$ \_\_\_\_\_ out of pocket met

\$ \_\_\_\_\_ Copayment: \_\_\_\_\_

\_\_\_\_\_ Combined Coverage: \_\_\_\_\_

\_\_\_\_\_ Other/Secondary Info: \_\_\_\_\_

\*The amount collected toward your deductible and/or co-insurance each visit may be LESS than what your total financial responsibility is. You will receive a bill for the remaining balance once your insurance processes your claims and info is received.

I certify that the information provided is true and accurate. I authorize Lafayette Physical Therapy, Inc (herein referred to as LPT) to bill my insurance carrier, and instruct my insurer to pay any benefits directly to LPT. I understand that any charges not covered by my insurance will be my responsibility. I agree to pay LPT any amount due after my insurance company has paid or made a decision on my claims. **Should my insurance pay me directly, I agree to forward the payment to LPT.** Co-payments and deductibles are due at time of each visit and co-insurances will be billed to you after we receive confirmation from your insurance. **Account balances are due upon receipt of a statement.** I authorize the release of any medical information necessary to process my claims. I authorized my insurance carrier to provide LPT with detailed benefits information. I authorize LPT to leave messages on the phone numbers I have provided. I may chose to not have messages left on the phone number provided by submitting a request in writing. I have read and understand the above information. A photocopy of this agreement shall be as valid as the original.

ATTENTION: Please sign after the insurance information is entered by the front desk.

\_\_\_\_\_  
Patient/Guarantor Signature Date



## Patient Policies and Agreements

Thank you for choosing Lafayette Physical Therapy for your physical therapy needs. We look forward to a rewarding relationship with you throughout your plan of care. The policies below are important to our relationship and assist us in providing you with the best quality care. Please let our staff know if you have any questions.

- Initial
- 1. Copayments, Deductibles and Co-Insurances:** Copayments are due at the time of service. Lafayette Physical Therapy, Inc. (herein referred to as "LPT"), asks that you pay a reasonable amount towards your deductible and/or coinsurance each visit. This collected amount typically does not cover your total share of cost. The front desk will inform you of your balance and you will receive a monthly statement when deductible and co-insurance balances are updated. ↕ Policy applies if your work comp case is denied.
  - 2. Account Responsibilities:** It is your responsibility to know your insurance coverage including deductibles, co-payments, visit limits, etc. Please verify your coverage with your insurance company. As a courtesy to you we will verify and bill your insurance carrier, however, you are ultimately responsible for the payment of your bill. You are responsible for any account balances not covered under your insurance, including deductibles and co-insurance amounts based on your insurance contract. Please be advised that a quote of eligibility and benefits is not a guarantee of payment. All benefits are subject to the eligibility, medical necessity, and the terms, conditions, limitations and exclusions of your individual health benefit plan at the time that the services are rendered. In the event that your insurance refuses to pay or does not pay within 90 days, you will be responsible for your balance in full. Many insurance companies have additional conditions that may affect your coverage. If your insurance carrier denies any part of your claim, or if you elect to continue therapy past the approved period, you will be responsible for your account balance.
  - 3. Late Policy:** Please be on time for your appointments. A professional staff member has been scheduled to treat you specifically. If you are late by 10 minutes or more you may be required to reschedule or wait for the next available appointment. If you are unable to be seen due to tardiness you will be charged the no show fee below. If you are running late please call our office as soon as possible so we can attempt to accommodate you at a later time. For Workers Comp please refer to No Show & Cancellation Policy.
  - 4. No Show & Cancellation Policy:** Our professional staffing is planned to accommodate scheduled visits. There is a \$65.00 charge for no show or same day cancellations (cancellations with less than a 24 hour notice for Tue-Fri appointments and notice after 3pm Friday for Monday appointments). LPT may discharge patients who fail to attend their scheduled appointments. Workers Compensation patients cannot be charged for missed visits, however, we are required to report them to your case manager which may affect your claim, and you may be required to schedule same day appointments only.
  - 5. Overdue Accounts & Fees:** Balances are due upon receipt of a statement or being notified by the front desk. Accounts 60 days or more overdue may be assessed a late fee of \$25 and assigned to a collections agency (Transworld Collection Agency). A \$25.00 fee will apply to any returned checks.
  - 6. Financial Hardship:** If you are experiencing difficulties and are unable to afford the cost of your therapy services please inform the front desk and our office will go over your options with you. Please let our office know immediately.
  - 7. Insurance Changes:** It is your responsibility to notify our office of any changes to your insurance. In the event that you do not inform us of an insurance change and your insurance does not pay you will be responsible for the unpaid balance.
  - 8. Insurance Ownership:** I guarantee that the insurance and personal information I have provided is true and correct and this is NOT a third party (someone else's) insurance, and that I am a direct beneficiary (self, spouse, or child) of the policy holder.

## Patient Policies and Agreements Continued

Initial  
9. **Cell Phones and Distractions:** As a courtesy to other patients and our staff please silence your cell phone while you are in our office. Please do not allow your phone to detract from your treatment. If you are unable to attend your full treatment due to urgent phone conversations you may be asked to re-schedule. A missed appointment fee may apply.

Initial  
10. **Children Requiring Supervision:** Please do not bring children to your appointments that require supervision. Your full attention is required for your full treatment. You may bring children who are capable of waiting for you in the waiting room unattended. We appreciate your understanding.

Initial  
11. **Informed Consent:** I understand the expected benefit of physical therapy and I understand that I can refuse any procedure prior to its performance. I hereby consent to the procedures which may be performed while I am a patient of LPT under the direction of a Licensed Physical Therapist. This may include but not limited to: examination/evaluation, physical testing, application of modalities such as hot/cold pack, electrical stimulation, ultrasound, etc, application of therapeutic procedures intended to improve function including therapeutic exercises, neuromuscular rehabilitation, gait training, manual or mechanical traction, soft tissue mobilization, joint mobilization, and any other procedure under the scope of physical therapy practice.

Initial  
12. **Important Notice from the Federal Government:** “It is unlawful to routinely avoid paying your copay, deductible or coinsurance payments...even if your medical office allows it. Unless you complete a “Financial Hardship” form and qualify for financial assistance under the Federal Standards, you may not routinely evade paying your responsibility portions for medical care as outlined in your insurance plan...” [Federal Register, December 19, 1994, the Office of Inspector General (OIG).] Contact the Office of the Inspector General, Department of Health and Human Services for more information: (202)619-1343, [paffairs@oig.hhs.gov](mailto:paffairs@oig.hhs.gov).

Initial  
13. **Privacy Acknowledgement:** I understand that I have the right to review LPT’s notice of privacy practices prior to signing this document. The full notice is posted in the waiting room and I have read and understand the notice. The notice of privacy practices describes the types of uses and disclosures of my protected health information and is summarized below. I further acknowledge that I have the right to request a copy of the notice.

**Consent to Use and Disclose Health Information:** I also understand that when necessary, LPT or anyone affiliated with our organization may contact me at any phone number provided. Your verbal communication and clinical records are strictly confidential. The following are the ways that we use your information and communications: (1) Treatment: information shared with our staff to provide quality treatment and billing, (2) Payment: information on your diagnosis, dates, treatment, etc. shared with your insurance company to process your claims, (3) Internal Administrative Activities: including quality control audits, software updates, etc, (4) Appointment Reminders: may be provided to a phone number or e-mail of your choosing. You may discontinue reminder calls or emails at any time by contacting our office in writing. (5) When required by Law, (6) To inform you of treatment alternatives or update you on relevant products or services offered, (7) Emergencies, (8) When you sign a release to have information shared.

Initial  
or N/A  
14. **Permission to Treat a Minor:** I consent to \_\_\_\_\_ being treated as a patient by LPT. I understand that at times it may be necessary to schedule appointments during school hours and that it is my responsibility to ensure he/she is on time for his/her treatment.

\_\_\_\_\_  
Parent or Legal Guardian Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Thank you for your cooperation.

I have read and understand the above policies and agreements.

\_\_\_\_\_  
Patient Name (Or Parent/Guardian if under 18)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



# LAFAYETTE PHYSICAL THERAPY, INC.

## Medical History and Pain Questionnaire

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Age: \_\_\_\_\_

1) Have you ever had any of the following problems or conditions?

Now	Past	Never		Now	Past	Never		Now	Past	Never	
<b>Heart Disease</b>											
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Congestive Heart Failure (CHF)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure Meds
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Angioplasty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Coronary Artery Bypass Graft (CABG)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Atherosclerotic Disease (CAD)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arrhythmia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Angina
<b>Lung Disease</b>											
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic obstructive pulmonary disease (COPD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia				
<b>Vascular Disease</b>											
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Acquired Respiratory Distress Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke/TIA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Peripheral Artery Disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes				
<b>General Medical Conditions</b>											
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis (rheumatoid/osteoarthritis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Broken Bones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastro Intestinal Disease (ulcer, hernia, reflux, bowel, liver, gall bladder)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney, bladder, prostate, urination problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurologic Disorders - MS, parkinsons, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness/ Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Metal pins/plates post fracture
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Visual Impairment - cataracts, glaucoma, macular degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis, HIV, or AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	MERSA/Staph infections/other infections* Specify
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Back Pain (neck pain, low back pain, degenerative disk disease, spinal stenosis, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prosthesis/ Implants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Impairment: very hard of hearing, even w/hearing aids
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies (Specify)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Numbness or Tingling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety/ Panic Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures

If YES to any of the above, please explain:

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PLEASE FILL OUT BACK PAGE ↗

2) Have you ever had **Physical Therapy** treatment before?  Yes  No

If yes, when and what was it for? \_\_\_\_\_

3) Have you ever taken **steroids (ie: asthma inhalers)** for an extended period of time?  Yes  No

4) Have you ever taken **anti-coagulants (ie: Aspirin)** for an extended period of time?  Yes  No

5) Do you **smoke**?  Yes  No If yes, how much and how often? \_\_\_\_\_

6) Have you had an **unusual weight loss or gain** recently?  Yes  No

7) Please list ALL **surgical procedures** you have had in the past and give the dates if possible:

\_\_\_\_\_

\_\_\_\_\_

8) Please list **recent diagnostic studies (X-Ray, MRI, CAT, etc.)** and give dates if possible:

\_\_\_\_\_

9) List any **medications** you are now taking. (Prescribed and over the counter: provide list if available)

\_\_\_\_\_

\_\_\_\_\_

10) Briefly describe the **history of your present injury, accident, or illness:** **Date of Injury:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

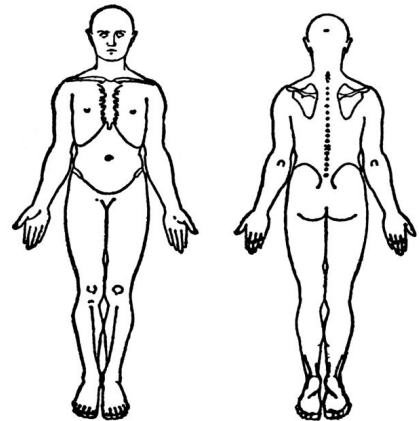
11) Do you have any pain with your condition?  Yes  No [If "Yes", please answer 11a-c]

a) What **aggravates** your pain?

- Bending  Twisting  Reaching  
 Sitting  Standing  Walking  
 Driving  Other: \_\_\_\_\_

b) What **eases** your pain?

- Stretching  Standing  Changing Positions  
 Lying Down  Cold  No Movement  
 Walking  Heat  Massage  
 Sitting  Other: \_\_\_\_\_



c) For the **current** condition, on a scale of **0 to 10**

Visual Analog Scale: 0 Being no pain, and 10 being worst pain ever.

What is your: Pain level **today**: \_\_\_\_\_ Pain at its **best**: \_\_\_\_\_ Pain at its **worst**: \_\_\_\_\_

12) Please **indicate and describe** on the body chart the **area of your problem(s) and/or your discomfort.**

13) Have you **fallen** in the past year?  Yes, \_\_\_\_\_ times.  No

If Yes, Did you sustain any **injuries** from the fall(s)?  Yes  No

Please explain the circumstances surrounding the fall(s) that you are reporting above, including injuries.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date