Copay / Coins / Deductible:
$_____

Rocky Hill Office
506 Cromwell Ave
Suite 103
Rocky Hill, CT 06067
Phone: (860) 721-9801

Suburban Physical Therapy & Sports Medicine Center, LLC

Cromwell Office
154 West St
Building 3, Suite C
Cromwell, CT 06416
Phone: (860) 613-0240

PATIENT RECORD (*Please fill out completely)*

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

Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

E-Mail Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Sex: Male / Female Please circle one: Single / Married / Divorced / Widowed / Separated

Employer: _____ Occupation: _____

Business Address, City and Zip Code: _____

How did you hear about us? _____

Insurance Verification: *SEE FORM ON PAGE 2*

PRIMARY INSURANCE:

Primary Health Insurance: _____

Subscriber ID #: _____ Group #: _____

Person Responsible for Account: _____ Relationship: Self / Spouse / Parent

Date of Birth: _____ Responsible Party Employed By: _____

Occupation: _____ Business Address, City & Zip Code: _____

SECONDARY INSURANCE:

Secondary Health Insurance: _____

Subscriber ID #: _____ Group #: _____

Person Responsible for Account: _____ Relationship: Self / Spouse / Parent

Date of Birth: _____ Responsible Party Employed By: _____

Occupation: _____ Business Address, City & Zip Code: _____

Please circle one of the following: **Motor Vehicle Injury / **Workman's Comp. Injury / **Other Liability Injury / Not Applicable

*Date of Accident: _____ Claim Number: _____

*Insurance Company: _____

*Adjuster Name: _____ Adjuster Phone #: _____

****Attorney's Name: _____ Phone #: _____

Office use only: **RH / CW**

Right * Left * Bilateral * n/a

Patient Code: _____

Primary Insurance Code: _____

Secondary Insurance Code: _____

Referring MD: _____ Script Date: _____

Dx 1: _____ _____

Dx 2: _____ _____

Dx 3: _____ _____

Dx 4: _____ _____

Dx 5: _____ _____

Dx 6: _____ _____

# of Visits: _____ Expiration Date: _____

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Verification of Benefits

for Out-Patient Physical Therapy (office setting)

Patient Name: _____

Insurance Comp.: _____ ID#: _____

Ins Member Phone #: _____

Date: _____

Spoke with (First and Last Name): _____

Effective Date of plan: _____

Copay $_____ / not applicable

Deductible $_____ (applied $_____) / not applicable

Co-Insurance % _____ / not applicable

Out of Pocket $_____ (applied $_____) / not applicable

Is a referral required from PCP: Yes / No ***If Yes***, Ref#: _____
From: _____to_____# of Visits: _____

Is Pre-authorization required: Yes / No ***If Yes,*** ph# to call: _____

Is authorization required after your first visit: Yes / No ***If Yes***, ph# to call: _____

Are MD scripts required: Yes / No

Visits allowed: _____ / per Calendar yr or Contract yr? ***If contract yr***: from _____ to _____
Visits are combined with: Physical / Occupation / Speech /Chiro
(circle all that apply)

Flex Spending Acct/Heath Reimbursement Acct. or Health Savings Acct.: Yes / No ***If Yes***, is it a Credit Card or is it Automatic?

Claims address:

_____

_____

******Call Reference#: _____******

Patient Signature: _____

Suburban Physical Therapy & Sports Medicine Center, LLC

MEDICAL HISTORY (*Please fill out completely)*

Referring Physician: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

***Have you had physical, occupational, speech therapy or chiropractic visits this year? YES NO**

****If Yes, please indicate how many visits you used this year:** _____

Current complaints/what brought you to Physical Therapy?

_____ How Long? _____

List 2 positions or activities that make your *symptoms* ***WORSE***:

1._____

2._____

List 2 positions or activities that make your *symptoms* ***BETTER***:

1._____

2._____

Current Medications: _____

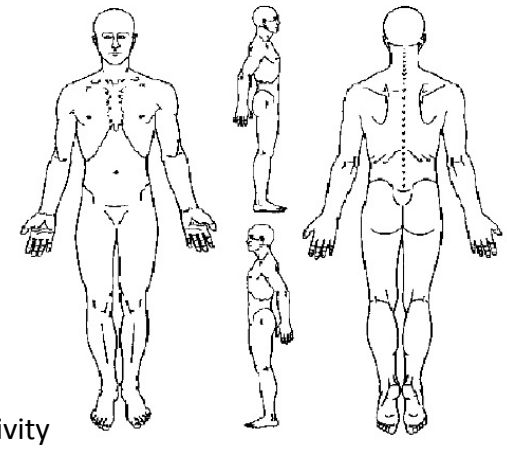
_____

Allergies (circle all that apply): Outdoor Indoor Pet Latex Other: _____

Body Chart

On the chart, please circle the areas where you are feeling symptoms *and* use the following letters to describe your symptoms:

A = Ache
P = Pins and Needles
B = Burning
S = Stabbing
N = Numbness
O = Other



My symptoms:

☐ Come and go ☐ Are constant ☐ Are constant but change with activity

How are you able to sleep at night due to your symptoms?

☐ No problem sleeping ☐ Difficulty falling asleep ☐ Awakened by pain ☐ Sleep only with medication

Using the 0 to 10 scale, with 0 being "no pain" and 10 being the "worst pain imaginable" please describe:

Your current level of pain while completing this form: 0 1 2 3 4 5 6 7 8 9 10

The best your pain has been during the past 24 hours: 0 1 2 3 4 5 6 7 8 9 10

The worst your pain has been during the past 24 hours: 0 1 2 3 4 5 6 7 8 9 10

EMERGENCY CONTACT LIST

Please indicate your primary physician and any family members and/or friends for emergency contacts, they will also be granted access to your medical records.

1. **Primary Care MD:** _____ Phone #: _____

2. _____ Relationship: _____ Phone #: _____

3. _____ Relationship: _____ Phone #: _____

This list will be valid for 1 year from the date signed.

Patient's Signature: _____ Date: _____

(Parent / Guardian, if patient is under 18 years of age)

Suburban Physical Therapy & Sports Medicine Center, LLC

PROCEDURES AND FINANCIAL POLICIES

APPOINTMENTS and CANCELLATIONS

We realize unexpected situations do occur. If your schedule does change and you have to cancel your appointment, we do ask that you call in advance so that we may offer that appointment time to another patient. If you will be late, please call, as it may be necessary to reschedule your appointment time. **WE DO CHARGE A $45 FEE, NOT COVERED BY INSURANCE, FOR MISSED OR CANCELLED APPOINTMENTS WITHOUT AT LEAST 24 HOURS NOTICE .**

Please initial: _____

PRIVACY POLICIES STATEMENT/ HIPAA

This authorization or photocopy thereof, will authorize the representatives of Suburban Physical Therapy and Sports Medicine Center, LLC to release my medical information to my referring physician, insurance carrier, and/or attorney in order to facilitate the processing of my claim for physical therapy services. I also acknowledge financial responsibility for the services provided and hereby authorize payment of insurance benefits directly to Suburban Physical Therapy and Sports Medicine Center, LLC. **I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.**

FINANCIAL INFORMATION

Your insurance policy is an agreement between you and your insurance company. ***It is your responsibility to verify your out-patient physical therapy benefits***. Please contact your insurance company to verify if your policy requires: prior authorization, authorization after a certain # of visits or an internal referral called in by your Primary Care Physician. **COPAYS, COINSURANCE and/or DEDUCTIBLE PAYMENTS ARE DUE AT THE TIME OF SERVICE. WE ACCEPT: Cash / Checks / VISA, Mastercard or Discover.**

****It is your responsibility to notify Suburban Physical Therapy & Sports Medicine Center, LLC of any changes to your insurance while treating at this facility.****

We bill your health insurance, auto medpay/PIP or worker's compensation directly. *If we encounter any problems with your insurance claims, we will contact you for your assistance. **You are ultimately responsible for your bill, no matter what your insurance may be.**

If payment is not received from your insurance carrier within 30 days of your treatment, it is your responsibility to pay the outstanding balance or to pursue payment from your insurance carrier. Unpaid accounts referred to our collection agency are subject to a 30% service charge along with collection fees and attorney fees. ***CHECKS RETURNED WITH NON-SUFFICIENT FUNDS WILL BE CHARGED A $35 FEE.*

♦ This portion is for Medicare patients only♦

Have you had a nurse, physical therapist or other healthcare provider from a home healthcare agency come to your house for ***any*** reason this year? *(Please circle one)* **YES** **NO**

If YES, please indicate facility and discharge date: _____

Medicare will *NOT* pay for out-patient physical therapy services if you are currently having or starting home healthcare services. **You need to be fully discharged from your home health care agency in order to start out-patient physical therapy.

MEDICARE VIEWS THE PATIENT USING HOME HEALTHCARE AS HOMEBOUND!

I HAVE READ AND UNDERSTAND THIS INFORMATION AND AGREE TO COMPLY WITH THE POLICIES SET FORTH HERE. THIS DOCUMENT IS VALID FOR 1 YEAR FROM THE DATE SIGNED.

Patient's Signature: _____ **Date**: _____

(Parent / Guardian, if patient is under 18 years of age)

Suburban Physical Therapy & Sports Medicine Center, LLC

Patient's Name: _____
(Please PRINT CLEARLY)

Please (✓) YES or NO to the following:		
Pregnancy Possibility	**YES** □	**NO** □
Smoker	**YES** □	**NO** □
ALS (Lou Gehrig's Disease)	**YES** □	**NO** □
Alzheimer's Disease and other Demenitias	**YES** □	**NO** □
Arthritis (Osteoarthritis and Rheumatoid)	**YES** □	**NO** □
Asthma	**YES** □	**NO** □
Atrial Fibrillation	**YES** □	**NO** □
Autism Spectrum Disorders	**YES** □	**NO** □
Cancer - Type: _____	**YES** □	**NO** □
Chronic Kidney Disease	**YES** □	**NO** □
Chronic Obstructive Pulmonary Disease (COPD)	**YES** □	**NO** □
Cystic Fibrosis	**YES** □	**NO** □
Depression	**YES** □	**NO** □
Diabetes	**YES** □	**NO** □
Eating Disorder	**YES** □	**NO** □
Heart Disease	**YES** □	**NO** □
Hepatitis - Type: _____	**YES** □	**NO** □
High cholesterol	**YES** □	**NO** □
High blood pressure	**YES** □	**NO** □
HIV/AIDS	**YES** □	**NO** □
Ischemic Heart Disease	**YES** □	**NO** □
Obesity	**YES** □	**NO** □
Osteoporosis	**YES** □	**NO** □
Pacemaker	**YES** □	**NO** □
Reflex Sympathetic Dystrophy (RSD) Syndrome	**YES** □	**NO** □
Schizophrenia or other Psychotic Disorders: _____	**YES** □	**NO** □
Stroke	**YES** □	**NO** □
Past Surgery(s): _____	**YES** □	**NO** □
OTHER: _____	**YES** □	**NO** □

Patient's Signature: _____ Date: _____
(Parent / Guardian, if patient is under 18 years of age)