Ferrell-Whited Physical Therapy Services, Inc.
Patient Information

Patient Information:

First Name: ____________________________ MI: _______ Last Name: _____________________________
Address: ______________________________________ City: ________________ ST: _____ Zip: __________
Home Phone: (____) ____-_____ Work Phone: (____) ____-_____ Cell Phone (____) ____-_____
DOB: ___/___/_____ SSN _____-____-______ Sex (check one) : ____ M ____ F
E-mail address: ____
Employer Name: ____
Employer Address: ____
Student Status (check one) : ____ Full time ____ Part time ____ Not applicable
Marital Status (check one): ____ Married ____ Single ____ Divorced ____ Widowed

Spouse Information: _____ Check here if not applicable

First Name: ____________________________ MI: _______ Last Name: _____________________________
Address if different from above: ____
Home Phone: (____) ____-_____ Work Phone: (____) ____-_____ Cell Phone (____) ____-_____
Employer Name: ____
Employer Address: ____

Guardian Information: _____ Check here if not applicable

First Name: ____________________________ MI: _______ Last Name: _____________________________
Relationship to Patient: ____
Address if different from above: ____
Home Phone: (____) ____-_____ Work Phone: (____) ____-_____ Cell Phone (____) ____-_____
Employer Name: ____
Employer Address: ____

Emergency Contact:

Name/Relation to Patient: ____________________________________ Phone number: _______________
In case of emergency, I authorize transport by ambulance to the nearest local hospital.

Signature of patient/guardian: ____ Date: _______________

Physician Information:

Primary Care Physician: ____
Referring Specialist, if applicable: ____

Referral Information:

Who may we thank for your referral?
__ Physician ___________________________ __ Web Site (www.ferrellwhited.com) __ Insurance
__ Friend/Family ________________________ __ Medina County Fair __ Our location/sign
__ Other ______________________________ __ Ad in Medina County Post __ Phone Book

I hereby authorize Ferrell-Whited Physical Therapy Services to release information regarding my treatments to my physician.
Signature: ____ Date: ______________

Ferrell-Whited Physical Therapy Services, Inc.

Insurance Information

Patient Information:

First Name: ______________________________ MI: _______ Last Name: ____________________________

DOB: ___/___/___ SSN: ____-___-_____

Primary Care Physician: ____

Referring Physician, if different: ____

Claim Information:

Type of Claim: Private Insurance Self-Pay Medicare Medicaid Auto

Workman's Comp: Claim #____

Caseworker Phone Number: __________________________________

Primary Insurance:

Policy Holder (check one) : ____ Self ____ Other

If other,

First Name: ______________________________ MI: _______ Last Name: ____________________________

DOB: ___/___/___ SSN: ____-___-_____ Relationship to Patient: ______________________________

Insurance Company: _____________________________________ Phone Number: ___________________

ID #: ____ Group #: ____________________________________

Secondary Insurance:

Policy Holder: Self Other

If other,

First Name: ______________________________ MI: _______ Last Name: ____________________________

DOB: ___/___/___ SSN: ____-___-_____ Relationship to Patient: ______________________________

Insurance Company: _____________________________________ Phone Number: ___________________

ID #: ____ Group #: ____________________________________

Benefits: Office Use Only

Deductible: ______________________ Co-Pay: _____________________ # of Visits: ________________

Referral Needed : ____ Y ____ N Pre-Cert Needed: ____ Y ____ N

Paid at % UCR: _______________ Effective Date: _____________

Diagnosis Codes: 1) ______________ 2) ______________ 3) _______________ 4) ________________

Notes: ____

____

I hereby authorize Ferrell-Whited Physical Therapy Services to release information regarding my treatments to my insurance companies. I recognize and accept my responsibility for payment of my therapy services.

Signature: ____ Date: ___________

Ferrell-Whited Physical Therapy Services, Inc.
Medical History Form

Patient Name:____________________________ **Date:**______________

MEDICAL HISORY

Please check any of the following conditions that apply to you: (Please explain all with an * below)

☐ Cancer*	☐ Heart Problems*	☐ Asthma/Emphysema/Bronchitis
☐ Arthritis*	☐ High Blood Pressure	☐ Other Lung Problems*
☐ Stroke/CVA*	☐ Pacemaker	☐ Hepatitis or Liver Problems*
☐ Headaches*	☐ Depression	☐ Kidney Problems*
☐ Diabetes	☐ Fibromyalgia	☐ Chronic Fatigue Syndrome
☐ Tuberculosis	☐ Epilepsy/Seizures	☐ Thyroid Problems
☐ Surgeries*	☐ Osteoporosis	☐ Bowel/Bladder Abnormalities

Please explain all * and describe any other problems we should be aware of:

____

____

____

Please list any prescription and over the counter medications with dosage you are currently taking:

____

____

____

____

____

Are you allergic to latex? Yes No
Are you allergic to medical tape? Yes No
Are you pregnant or could you be? Yes No
Do you exercise? Yes No

Please indicate your current activity level.

0 = Bedrest or no activity 10 = normal activity

Current level: 0 1 2 3 4 5 6 7 8 9 10

<u>Ferrell-Whited Physical Therapy Services, Inc.</u>

Acknowledgement of Receipt of Notice of Privacy Practices

I, (name of patient) ________________________________, acknowledge and agree that I have received a copy of Ferrell-Whited Physical Therapy Services Notice of Privacy Practices.

Patient Signature____Date__________

Patient Legal Representative (if applicable)_________________________ Date__________

Print Name of Legal Representative____
Relationship to Patient____

<u>FOR CLINIC USE ONLY:</u>

_______________________________________ of Ferrell-Whited Physical Therapy Services Inc., made the following good faith efforts to obtain the above-referenced individual's written acknowledgement of receipt of the Notice of Privacy Practices.

Privacy Practices:
(Identify the efforts that were made to obtain the individual's written acknowledgement, including the reasons (if known why the written acknowledgment was not obtained.)

Ferrell-Whited Physical Therapy Services, Inc.

700 East Washington Street E4
Medina, OH 44256
Phone: (330) 722-3781
Fax: (330) 725-6294

The following are our policies regarding cancellations and no-shows. We take this subject seriously at the clinic, because it can make the difference between whether you succeed in your treatment or not. Usually your referring doctor and/or your therapist have prescribed a set frequency of treatment. Showing up as scheduled for these visits is your most important job. Other than that, all you need to do is follow your therapist's instructions and we will be able to help you achieve your goals in treatment.

- We require 24 hours notice in the event of a cancellation. It is your responsibility, when you call in, to have an alternative time in mind that will ensure you get in the full prescribed number of treatments that week whenever possible. (In some cases, this may not work since some forms of treatment do not work well if given two sequential days.)
- There is a $35.00 charge for a cancellation without proper notice. This charge will not be covered by insurance, but will have to be paid by you personally.
- For Worker's Compensation and Personal Injury patients documentation of any missed appointments is forwarded to your Case manager and Primary Physician and this could jeopardize your claim.
- You may need to see a therapist other than the one who normally treats you if you re-arrange your appointment. All of our therapists are experienced professionals, and they will study your patient chart, so you will be in good hands. You will return to your original therapist in the next regularly scheduled visit.
- Please understand that your pain will probably increase and decrease as your course of treatment progresses and before it is finally erased. Either condition can seem to be a reason not to com in: a) you're feeling worse and think the treatment is not working, or b) you're feeling better and it is a great day golfing. Neither of these conditions is legitimate as a reason not to come: a) if you're in pain, come in and get it fixed, b) if you're out of pain, now is the time that we can begin doing some real correction of the underlying causes of your problem, educate you so you won't re-injure yourself, etc.

When you don't show as scheduled, three people are hurt: You, because you don't get the treatment you need as prescribed by the doctor and/or PT; the therapist, who now has a space in their schedule since the time was reserved for you personally; and another patient who could have been scheduled for treatment if you had been given proper notice.

Please co-operate with us in this regard. We are looking forward to working with you.

Patient Signature____ Date: ____________

Ferrell-Whited Physical Therapy Services, Inc.
Financial Agreement

1. As a courtesy, we will bill your insurance company for your physical therapy visit. You are responsible for your deductible (if any) and any co-payment required by your insurance. Please keep in mind that you and/or your employer have a contract with the insurance company. Your bill is ultimately your responsibility. *If you know you have not met your deductible yet this year, we encourage you to arrange weekly payments on your account until your deductible is met. We will still submit your bills to your insurance and accept assignments as arranged with your insurance carrier

2. If you need referral from your primary doctor to attend physical therapy you must make sure it is obtained **prior to your last visit**. Although we will assist in the process, all referral requests are the patient's responsibility. If not obtained, you are held responsible for your charges not **your insurance company**.

3. If we have not received payment on your account within **8 weeks** of your **last date of service**, or if we receive a denial of coverage we require that you either:
    a. Pay your account in full
    b. Arrange payments with our billing office

    You will receive month statements as to the status of your account. We will, of course, work with you to straighten out any insurance problems and/or submit any needed paperwork to support your claim

4. If you have a balance on your account after your insurance has paid for their portion, we expect full payment of your portion within 30 days of your billing statement (this is listed under the "patient balance" section of your bill). Service charges of 1.5% will be charged if you skip or do not make the minimum payment. Please call the billing office if you have questions regarding your account or are unable to make a minimum payment for the month.

5. Your account may be turned over to collection if we have not received payment (or make arrangements for payment) within 90 days of your last treatment. IF this account should be turned over for collection a onetime fee of $35.00 will be charged to your account.

Automobile Accident/Litigation:

1. See "Financial Policy for Accident/Litigations" on separate sheet

Workers Compensation (BWC or Managed Care)

1. Patients must submit their claim number or authorization for treatment on the 1st visit.
2. Although WC covers all authorized visits, you are still ultimately responsible for your bill if you are denied coverage (if WC contests or denies your claim).

Supplies: Sometimes there are extra supplies that your therapist may determine to be beneficial to your treatment (electrodes, tape, putty, theraband, etc). Insurance companies **rarely** pay for these "extra supplies". Out therapist will discuss this with you – as obtaining these items are always your choice.

Payment is expected at time of purchase of supplies. We will give you a bill for you to submit to your insurance company if you wish.

I understand the financial policies outlined above and understand my financial responsibility for the physical therapy services rendered. I, ____, so hereby authorize payment of medical benefits to Ferrell-Whited Physical Therapy Services, Inc. 700 East Washington Street, Medina, Ohio for services described herein.

Signature ____ Date: ____________________________