Keck Physical Therapy
271 Old Barn Road, Unit C, Hendersonville, NC 28791 * Office (828) 890-4905 * FAX (828) 890-8123
Website: Keckpt.com

PATIENT INFORMATION

Last Name	First Name	MI
Street Address	City/State	Zip

Home Phone	Cell Phone	Email	Reminders YES NO

Birth Date	Gender M F	Marital Status Married Single Widow

Employment	Relationship to Insured	Student
○ Retired ○ Full Time ○ Part Time ○ None	○ Self ○ Spouse ○ Child ○ Other	○ Full Time ○ Part Time

Primary Physician	Referring Physician

Emergency Contact Name	Contact Number

If surgery was performed for this referral, list date of surgery	List physician follow-up visit for this surgery

Is this injury a result of a car accident? ____ Yes____ No If Yes, ask for a Claims Adjuster form.	Have you received Physical Therapy services in the past year in another facility? _____ Yes _____ NO

What are your goals by coming here?	What is your current complaint?

INSURANCE INFORMATION

Primary Insurance: _____ Policy Number: _____

Secondary Insurance: _____ Policy Number: _____

Relationship to Insured: _____ self _____ spouse _____ child _____ other

If insurance is in spouse or parent name, please list the following information:

First and Last Name: _____ Birthday: _____

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PATIENT HISTORY

At this time would you say your health is: Excellent Good Fair Poor
List all surgeries:

_____

_____

Medical History: Circle all that apply.

Alzheimer's	Current Infection	Fracture or Suspected Fracture	Immunosuppression	Osteoarthritis
Cardiovascular Disease	Diabetes Type I	High Blood Pressure	Lupus	Parkinson's
Cauda Equina syndrome	Diabetes Type II	History of Cancer	Muscular Dystrophy	Rheumatoid Arthritis
Cerebral Vascular Accident	Fibromyalgia	Huntington's	Obesity	Traumatic Brain Injury

List current medications: (or provide a copy)

_____

_____

_____

What are your hobbies or favorite things that you do that is limiting your ability to perform:

_____

_____

List any treatments, tests, xrays, MRIs, scans you have received for this current condition:

_____

_____

Rate Your Pain

1 = No Pain 5 = Moderate Pain (time to take meds) 10 = Worst possible pain

At its Worst: _____ out of 10. Currently: _____ out of 10. At its Best: _____ out of 10.

Due to privacy regulations, we require your permission to leave messages on your answering machine or with any individual who answers the number you provided. _____ Yes _____ No

I authorize Keck Physical Therapy to text message my cell phone for appointment reminders. I also understand that ***I cannot text message Keck Physical Therapy to cancel or reschedule my appointments, and that I must call the office to handle these matters.*** _____ Yes _____ No

HIPPA DISCLOSURE STATEMENT:
I acknowledge that I have been informed of the Provider Notice of Practices which is located in the reception area of this facility. _____ (initial)

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Financial Policy

We accept cash, checks and debit/credit cards. A $25 fee will be added to your account for each returned check and future visits will need to be paid in cash or credit card.

YOUR RESPONSIBILITIES:

- Your deductible / copayment: We are under contractual obligation to collect required co-payments at the time of service.
- Cancellations: We request that you call our office within 12-24 hours of your scheduled appointment time if you need to cancel or reschedule. We understand that circumstances do occur and these will be considered.
- No Call/No Show: A $25 fee will be applied to your account for any missed visits if you fail to contact us before your scheduled time. This fee is not covered by your insurance.
- *Repeated changes with or without our notice, multiple cancellations, will result in restricting your ability to schedule future appointments.*

INSURANCE COVERAGES:

- **Medicare:** We are a Medicare provider and accept assignments from Medicare. If you have supplemental insurance, no payment (except for disclosed non-covered items) is due at the time of service. If you do not have secondary insurance coverage, you are responsible for a percentage of the approved charges (generally 20%) and for any non-covered services or supplies. **NOTE: Please advise us if you have received physical therapy within this calendar year as this will affect your total available Medicare benefits.**
- **Medicare Advantage Plans:** You will have a copayment which will be due at the time of service.
- **Self-Pay:** We have a self-pay fee schedule that is available. Payment in full is expected at the time of service. Should your account become delinquent of the agreed terms, we hold the right to withhold further treatment until either payment or a new payment arrangement is made.
- **In-Network Insurance:** If you have health insurance, we will be glad to file for you provided you supply the proper forms and information.
- **Out-of-Network Insurance:** Should we not be in-network with your provider, the self-pay policy will apply and be billed toward your out-of-network benefits within your plan.
- **Workman's Compensation:** All Workman's compensation claims and authorizations must be verified in writing. Verbal or telephone verifications are not acceptable.
- **Personal Injury with Attorney:** You, and not your attorney or third party, are responsible for your charges. The two options are to attend as a self-pay and then submit the statements to your personal health insurance or responsible car insurance adjuster OR provide a contact name, phone number, claim number in order for us to properly bill your claims.

I have read the above policy. I understand and agree with my responsibilities as well as benefit assignment to Keck Physical Therapy.

Signature: _____ Date: _____