Louisiana Physical Therapy Centers of Pineville, LLC

Louisiana Physical Therapy Centers of Pineville, LLC
1135 Expressway Drive, Suite 200A
Pineville, LA 71360
(318) 487-6525 Fax: (318) 487-6527

Patient Information:

Name: _____

First Middle Last

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Other Contact: _____

Email: _____

Social Security # _____ Dob: _____

Gender: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single

Place of Employment: _____

Name of School If Student: _____

Referring Dr: _____

Next Dr. Appt: _____

Are You Currently Receiving Home Health? ☐ Yes ☐ No

Do You Have an Attorney Related to This Injury? ☐ Yes ☐ No

If Yes, Name: _____ Phone# _____

How Did You Hear About Our Clinic? _____

Primary Insurance: _____

Policy Holders Name: _____

Date of Birth: _____ Social Security# _____

Secondary Insurance: _____

Policy Holders Name: _____

Date of Birth: _____ Social Security# _____

Please List Medications on The Next Page That is Provided.

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	Name of Drug\Supplement	Dosage	Morning, Noon and/or Night	Route of Administration	Reason for Usage
Ex:	XXXX/xxxxxxxxxx	20mg	Morning & Night	Taken Orally	High Blood Pressure
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					

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Patient Name: _____

Date of Injury: (If Known) _____

Check Which Apply to Your Symptoms (If Known)

- ☐ Work Related Injury
- ☐ Recurrence of Previous Injury
- ☐ Motor Vehicle Accident
- ☐ Injury Related to Lifting
- ☐ Athletic Injury
- ☐ Cause Unknown

Have You Had Any Related Surgery to This Injury? ☐ Yes ☐ No

If Yes, Explain and Give Approximate Date: _____

Select Any of The Following Condition/ Complaints That You Have Had in The Last 6 Months?

- ☐ Pregnant
- ☐ Hernia
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Headaches
- ☐ Osteoarthritis
- ☐ Chest Pain Angina
- ☐ Seizures
- ☐ Skin Abnormalities
- ☐ Ringing in Ears
- ☐ Cancer
- ☐ Recent Fractures
- ☐ Arthritis
- ☐ Nausea
- ☐ Rheumatoid
- ☐ Pacemaker
- ☐ Heart Disease
- ☐ Dizziness
- ☐ Metal Implants
- ☐ Other: _____

Please Carefully Complete This Drawing Using the Symbols Listed Below to Help us Better Understand Your Pain and Current Complaints.

/// DULL/ACHING/THROBBING

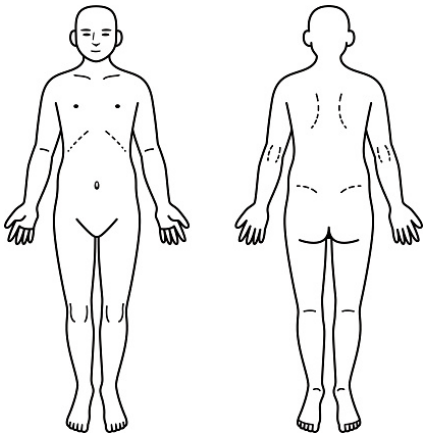
XX SHARP/STABBING

BB BURNING

== NUMBNESS

::: TINGLING

SSS CRAMPING



I Acknowledge That the Information I Have Provided Is True and Correct.

Relation to Patient _____

Signature _____ Date _____

Louisiana Physical Therapy Centers
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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Louisiana Physical Therapy Centers of Pineville to use and disclosure protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Louisiana Physical Therapy Centers of Pineville's Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Louisiana Physical Therapy Centers of Pineville reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Louisiana Physical Therapy Centers of Pineville's Privacy Officer at 1135 Expressway Drive, Suite 200A, Pineville, LA 71360.

With this consent, Louisiana Physical Therapy Centers of Pineville may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TIP, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results among others. Louisiana Physical Therapy Centers of Pineville may also contact me at my home or other alternate location and leave a voice mail or in person concerning my account.

With this consent, Louisiana Physical Therapy Centers of Pineville restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Louisiana Physical Therapy Centers of Pineville's use and disclosure of my PHI to carry out my TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Louisiana Physical Therapy Centers of Pineville may decline to provide treatment to me.

I also give my consent to be treated in the gym in front of other patient's that may be attending therapy.

_____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

_____ _____

PATIENT'S NAME DATE

Louisiana Physical Therapy Centers
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PATIENT'S EXTENDED SIGNATURE AUTHORIZATION

*I acknowledge that the information I have provided is true and correct. I also understand that LAPT will make every reasonable effort to collect on this account: however, if my account must be turned over for collection, I will be responsible for any fees associated with the collection process.

*I realize that my participation in the Louisiana Athletic Club facility could involve risk of injury. I hereby expressly assume all the delineated risk of injury and all other possible risk of injury which occur by reason of my participation.

*We file your insurance as a courtesy to you. Your insurance is intimately a contract between you and your insurance company. If, for some reason, whether it be pre-existing or they did not receive the claims, etc. and they do not pay the claim, it is necessary that you understand that you are responsible for payment to our office. (If your insurance company does not pay, you are responsible.)

*I authorize payment of medical benefits to undersigned physician or supplier for physical therapy services described below. (You are authorizing your insurance company to pay LAPT and not the patient.

*I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. (You are authorizing the release of any information to the insurance company to get the claims paid.)

_____ _____

SIGNATURE DATE

Louisiana Physical Therapy Centers
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LOUISIANA PHYSICAL THERAPY CENTERS OF PINEVILLE

All insurance companies placed a limit on the amount they pay for outpatient physical therapy, speech therapy & home health services combined.

Louisiana Physical Therapy Centers of Pineville will not compromise your care in any manner; we will assist you in tracking your visit and limits. If you reach your limit, we will work with you on a self-pay basis to continue your care so that your functional outcome will be maximized. Upon reaching your allowable limit, you will also have the option of receiving covered services in a hospital outpatient therapy setting.

To assist us in tracking your available benefits, please answer the following questions:

1. Have you received any Home Health since 1/1/2017? ☐Yes ☐No

   If yes, select the location in which the treatment was received and the date the Home Health ended.

   ☐Hospital ☐Home Heath ☐Outpatient Clinic ☐Rehab Facility ☐Doctor's Office

   Date ended _____

2. Have you received any Physical Therapy since 1/1/2017? ☐Yes ☐No

   If yes, select the location in which the treatment was received.

   ☐Hospital ☐Home Heath ☐Outpatient Clinic ☐Rehab Facility ☐Doctor's Office

3. Have you received any Speech Therapy since 1/1/2017? ☐Yes ☐No

   If yes, select the location in which the treatment was received.

   ☐Hospital ☐Home Heath ☐Outpatient Clinic ☐Rehab Facility ☐Doctor's Office

If you are unsure about the above question, please ask a staff member for assistance.

I have read and understand the above information.

_____ _____

SIGNATURE DATE