



For official use only:
Physical Therapist: _____
Diagnosis Code: _____

Patient's Name: _____ Home Phone: _____

Address: _____ Cell Phone #: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Sex: Male Female S.S. #: _____

Employer: _____ Work Phone: _____

Employer address: _____ City: _____ State: _____ Zip Code: _____

Referring Physician: _____ Physician's address: _____

City: _____ State: _____ Zip Code: _____ Phone #: _____

If Married: Spouse's Name: _____ Employer: _____

Home Phone: _____ Work Phone: _____ DOB: _____

PLEASE COMPLETE IF PATIENT IS A MINOR:

Mother/Guardian's name: _____ Address: _____

City: _____ State: _____ Zip Code: _____ DOB: _____

Employer: _____ Address: _____

City: _____ State: _____ Zip Code: _____ Phone #: _____

Father/Guardian's name: _____ Address: _____

City: _____ State: _____ Zip Code: _____ DOB: _____

Employer: _____ Address: _____

City: _____ State: _____ Zip Code: _____ Phone #: _____

INSURANCE INFORMATION: Please present the front office with insurance cards

Primary Insurance Carrier's Name: _____ Address: _____

Subscriber's Name: _____ Employer Name: _____

Subscriber's ID #: _____ Group #: _____ Date of Birth: _____

Secondary Insurance Carrier's Name: _____ Address: _____

Subscriber's Name: _____ Employer Name: _____

Subscriber's ID #: _____ Group #: _____ Date of Birth: _____

Is treatment a result of a: On the job injury Auto Accidental

Date of Injury: _____ Claim #: _____

Emergency Contact: Name: _____ Phone: _____

I authorize Grandview Physical Therapy to use and disclose health and medical information for the purposes of treatment, payment and health care operation. Under all circumstances I assume final responsibility for my account understanding that in the event my account becomes delinquent, I agree to pay accrued finance charges, court costs and attorney fees. I consent to physical therapy services prescribed by any physician. I authorize payment of medical benefits by my insurance company to Grandview Physical Therapy for services rendered. I have received this practice's Notice of Privacy Practices written in plain language.

Signature: _____ **Date:** _____

Authorization for Release of Information: I authorize the release of medical information to the person(s) named below:

All Medical and Billing Information

Appointment Information Only

Name, Relationship to Patient & Date

Name, Relationship to Patient & Date

Name, Relationship to Patient & Date

Patient History



GRANDVIEW
PHYSICAL THERAPY

Grandview Physical Therapy, P.S.

Name _____ Date _____

I. What is your problem or injury? _____

2. How did your problem or injury begin? _____

3. How long ago did it begin? _____

4. What is your type of work? _____

5. Are you working? Yes No

If no, is it because of your problem? Yes No

6. Before this injury were you completely free of symptoms? Yes No

7. Have you ever had anything similar before? Yes No

8. What, if any, treatments have you had for this current problem?

Check one: Physical therapy Chiropractic Medical Other

9. What eases your pain? Sitting Standing Walking Lying down

10. What makes your pain worse? Sitting Standing Walking Lying down

11. Do you have any feelings of pins and needles or numbness?

Yes No

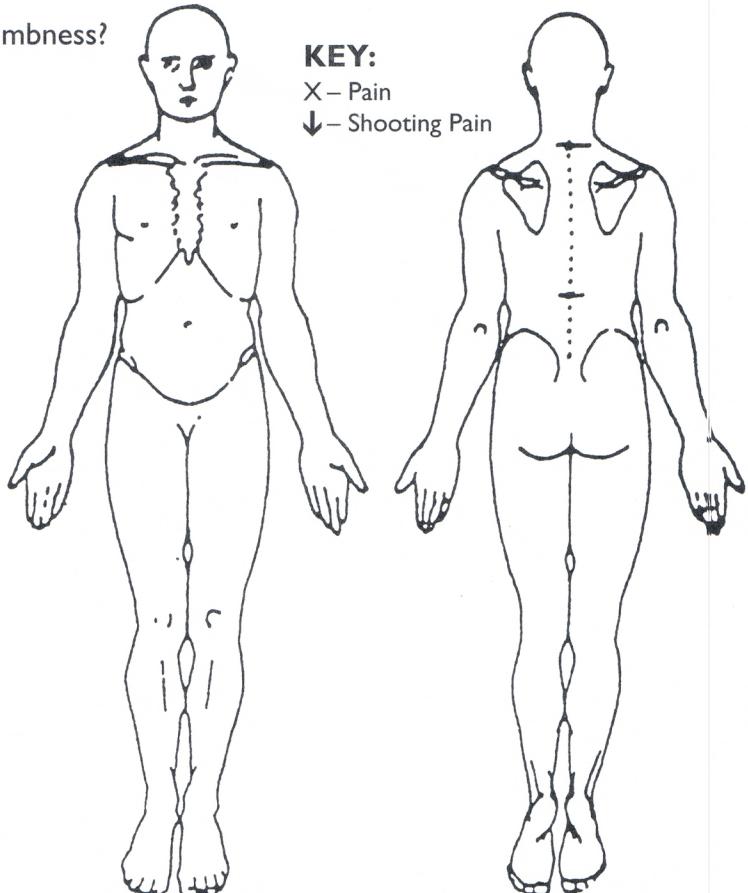
12. Do you have any other problems?

Yes No

13. Are you taking any medications?

Yes No

What kind? _____



14. Show on the body figure the places of discomfort.

NEW PATIENT INSURANCE INFORMATION FORM:

Revised 3/3/04

Patient's name: _____

(1) Insurance Company: _____

(2) Insurance Company: _____

Insurance Phone #: _____

Insurance Phone #: _____

INSURED INFORMATION:

1st Insurance:

Name: _____

Date of birth: _____

Date of birth: _____

Social Security #: _____

Social Security #: _____

Policy or Claim #: _____

Policy or Claim #: _____

DOI/DOA: _____

DOI/DOA: _____

Dx Code: _____

Dx Code: _____

CHECKLIST FOR CALLING INSURANCE COMPANIES:

(1st Insurance)

(2nd Insurance)

Name of person calling insurance: _____

1. Effective date of patients policy: _____

2. Did they have max? _____

Dollar amount for PT or max. # of visits? _____

3. What percentage does insurance pay? _____

4. What is patient portion (i.e. % or co-pays)? _____

5. Has deductible been met? _____

6. Do they need pre authorization? _____

7. Do they need doctor prescription? _____

8. Name of person speaking to: _____

Date: _____

DSHS Patients: Ask the patient if they have received physical therapy from any other physical therapy clinic so far this year: Yes _____ No _____

If yes, how many visits have they had: _____

DSHS patients are limited to 12 treatments per year unless they have a special diagnosis.

Is the patient straight DSHS: Yes _____ No _____ if no, phone call is required.

Is the DSHS patient PBC, Regence or CHIS/CHPW: Yes _____ No _____ if so, pre-authorization and a phone call are required.

We are contract to see Molina patients

If DSHS card states CNP they have physical therapy coverage. Any other initials phone call is required.

Medicare Patients: Does the patient have a Medicare card: Yes _____ No _____

If no, a phone call to Medicare to verify coverage is required.

