Patient Data Sheet

Patient Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Social Security Number: _____
Phone Numbers
Home: _____ Work: _____ Cellular: _____

Email Address: _____

Employers Name and Address: _____
_____
Occupation: _____ Employment Status: Full time Part Time Student Retired

Marital Status: Married Single Divorced Widowed

Emergency Contact Name: _____
Relationship: _____ Phone Number: _____

Referring Physician Name: _____
Address: _____

How Did You Hear About Us: Friend Relative Dr Case Mgr Attorney Phonebook Web Page
Other Advertisement: _____

Health Insurance- Medicare/Secondary- BC/BS/MM/PC- MVA-WC-HMO-Private-Keystone

Insurance Company Name: _____
Address: _____ Phone Number: _____
ID#: _____ Group#: _____

Secondary Insurance: _____
Address: _____ Phone Number: _____
ID#: _____ Group#: _____

Date of Accident/Injury: _____ Insured Name: _____
Insurance Company Name: _____
Address: _____
Adjuster: _____ Phone Number: _____
Claim#: _____ Policy#: _____
Attorney's Name: _____ Phone Number:_____
Address: _____
If Accident, Please Explain: _____

Insurance Authorization and Assignment of Benefits
I hereby authorize Penn Therapy Associates to furnish information to Insurance carriers concerning my illness and treatment and I hereby assign to Penn Therapy Associates all payment for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Signature: _____ Date: _____
(insured or guardian signature)

Patient Information Form

Name: _____ **Date:**_____
Age: _____ **Height:**_____ **Weight:**_____

DATE OF ONSET: Injury/Problem/Surgery:_____

ARE YOU RECEIVING HOME CARE OF ANY KIND? YES or NO
(Includes wound care, nursing care and PT, OT, Speech)

Briefly state previous treatment, if any:_____
_____

Have you suffered a fall in the past year? (*please circle)* **YES or NO**

Do you have now, or have you ever had, any of the following? Please place a check next to the ones that apply to you.

DIABETES	_____	**RESPIRATORY PROBLEMS**	_____
HIGH BLOOD PRESSURE	_____	**ALLERGIES**	_____
PACEMAKER	_____	**PREVIOUS SURGERY**	_____
HEADACHES	_____	**SEIZURES**	_____
KIDNEY PROBLEMS	_____	**METAL IMPLANTS**	_____
NERVOUS DISORDERS	_____	**DIZZINESS**	_____
HERNIA	_____	**CANCER**	_____
PINS & NEEDLES	_____	**BLADDER PROBLEMS**	_____
FRACTURES	_____	**BOWEL PROBLEMS**	_____
CURRENTLY PREGNANT	_____	**OSTEOPOROSIS**	_____
CIRCULATORY DISEASE	_____	**RECENT WEIGHT LOSS**	_____

If YES to any of the above, please explain and give appropriate details:_____
_____
_____

CURRENT MEDICATION:_____
_____
_____
_____

Have you had any x-rays, CAT scans, MRIs, or other diagnostic tests for your recent disorder? YES_____NO____. If YES, please explain the findings as you understand them:_____
_____

Is there anything else you think I should know about your general health, or current condition? Please explain and, if necessary, we can discuss it:_____
_____
_____

The above information is required per Medicare regulations.

PENN THERAPY ASSOCIATES, INC

To Our Patients Regarding Cancellations and No-Shows

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.)

- 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 do 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 come in: a) you're feeling worse and think the treatment is not working or, b) you're feeling better and it's a great day for golf. 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 not in 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 given proper notice. Please co-operate with us in this regard. We're looking forward to working with you.

Patient Signature:_____ Date: _____

Federal Tax ID#: 23-3015044
Physical Therapist: Mark E. Reitz, P.T.
Licensed Physical Therapist
License#: PT-003694-L
Trading As: Penn Therapy Associates, Inc.

MEDICARE PAYMENT AUTHORIZATION FORM

_____
Name of Medicare Beneficiary (Please Print)

_____
Medicare Number

I request that payment of authorized Medicare benefits be made either to me, or on my behalf to Penn Therapy Associates, Inc., for services furnished to me by this provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

_____
Medicare Beneficiary's Signature

____/____/_____
Date

authorize