Grelot Physical Therapy

**PATIENT INFORMATION**

Name:_____DOB:____/____/____Social Security #:_____-____-_____

Address:_____City:_____State:_____Zip:_____

Home Phone:_____Work Phone:_____Cell/Alt Phone:_____

Marital Status: M S D W O Patient's Sex:_____E-Mail:_____

Emergency Contact:_____Relationship:_____Phone:_____

**DIAGNOSIS/COMPLAINT INFORMATION**

Referring Doctor: _____Diagnosis: _____

Injury caused by: ___Auto _____Work _____Other: _____

Date symptoms began: _____(If unknown, please be approximate)

**INSURANCE INFORMATION**

___Private Insurance ___Medicare ___HMO ___WC ___Private Pay ___Other:_____

Name of Insurance company(s):_____

Policy/ID#:_____Group#:_____Effective:_____

Policy Holder:_____Relationship to you:_____ DOB:_____

Policy Holder's SS#:_____-___-_____Contact Phone:_____Contact Person:_____

**EMPLOYER INFORMATION**

Employer: _____Address: _____

Position/Occupation: _____

***CONSENT FOR TREATMENT AND FINANCIAL RESPONSIBILITY***

I hereby consent to have Grelot Physical Therapy provide the treatment and care prescribed by my physician or dentist. I understand this consent may be revoked by me at any time. I also hereby give lifetime authorization for payment or insurance benefits to be made directly to Grelot Physical Therapy for services rendered. I understand that I am financially responsible for all charges not paid for by my insurance company. ***I understand that I will be charged $25 for each missed visit which has not been cancelled within 24 hours of my scheduled appointment time.*** I will personally be responsible for this charge, as insurance companies do not reimburse for fees due to lack of compliance. I agree that if my balance becomes delinquent, defined as 90 days past due, and is referred to a collection agency or attorney, I shall be responsible for collection fees equal to 33 1/3% of the balance due in addition to the balance. I further understand and agree that if legal action is taken to collect the balance, I shall also be responsible for all court costs. I hereby waive my rights under the laws and constitution of (Alabama, Georgia, or Florida) or any other state, to exempt my real personal property from execution. I further agree that a photocopy of this agreement is as valid as the original. I further authorize that my signature on this form constitutes assignment of benefits to Grelot Physical Therapy.

_____ _____

**Patient's Signature** **Date**


# GRELOT PHYSICAL THERAPY

5901 Grelot Rd.
Bldg B, Suite B
Mobile, AL 36609
Phone: (251) 343-1178
Fax: (251) 343-1741

Welcome to Grelot Physical Therapy. Your physician or dentist has referred you to physical therapy with a given diagnosis. Based on this referral, our therapist will perform an evaluation, develop a treatment plan, and treat your disease or injury or condition. We continually re-evaluate your progress and regularly report your progress to your physician or dentist.

Treatments are by appointment only. It is important to be prompt and keep your scheduled appointments. In consideration for us and other patients requiring care, *we ask that you give us 24- hours notice for any appointment cancellation*. We have voicemail for your convenience during non- working hours, weekends and holidays. **There is a $25 cancellation fee for each missed appointment.** You will personally be responsible for this charge as insurance companies do not reimburse for fees due to lack of compliance. Failure to give 24 hours notice, multiple cancellations, and rescheduling of appointments could result in discharge from our facility.

If you have health insurance, we will bill your insurance company for the services rendered. In order to provide this service, you will need to provide us with any and all information necessary to effectuate the billing process. *Please be advised that you are ultimately responsible for physical therapy services, medication, and patient billable supplies which are not covered by your insurance company.*

Our primary goal is to provide you with the highest quality physical therapy care and treatment possible along with assisting you to a speedy recovery. Please help us to assist you in your recovery by keeping all of your scheduled physical therapy appointments and performing your home programs as directed.

**All copayments, coinsurances, deductibles and non-covered charges for physical therapy services will be collected at the end of each visit.** We accept payment in the form of cash, checks, MasterCard, Visa and Care Credit. Any accounts that remain delinquent, defined as 90 days past due and are referred to a collection agency or attorney, you will be responsible for a collection fee equal to 33 1/3% of the balance due in addition to your balance.

In the event your account is placed with a collection agency or an attorney to recover the amount you are responsible for, all fees and costs associated with the collection process will be your responsibility. This includes any and all attorney fees and agency collection fees charged by any outside company to collect your debt.

Your signature below indicates that you understand and agree to our office and payment policies. Your signature also confirms that you will comply with your obligations listed above.

_____ _____

**Patient's Signature** **Date**

Kristján Friðriksson Physical Therapy, Inc.
Hands-On Treatment

GRELOT PHYSICAL THERAPY

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Acknowledgement of Receipt of **Notice of Privacy Practices**

**Grelot Physical Therapy** reserves the right to modify the privacy practices outlined in the notice.

**Signature**
I have received a copy of the Notice of Privacy Practices for Grelot Physical Therapy.

_____
Name of Patient (Print or Type)

_____
Signature of Patient

_____
Date

_____
Signature of Patient Representative
(Required if the patient is a minor or an Adult who is unable to sign this form)

_____
Relationship of Patient Representative

# NOTICE TO MEDICARE PATIENTS

As of January 1, 2017, Medicare has enforced a policy which caps any type of therapy benefits at a combined $1,980.00 per year. This means that if the charges for your outpatient therapy visits exceed $1,980.00 for the year, Medicare will not cover those services. Even if your doctor has deemed it medically necessary.

Please inform Grelot Physical Therapy if you have had any therapy visits (Physical Speech, Occupational Therapy, Home Health Care, Inpatient Facility Care, etc.) since January of this year. It is important that we know this information so that you, as a patient, do not have to pay for services over what Medicare will allow you.

Please sign this form, acknowledging that you understand this Medicare policy. If you have any questions, please do not hesitate to ask.

Thank you for your cooperation and for choosing Grelot Physical Therapy for your physical therapy needs!

____ I am **not** currently in an inpatient facility receiving treatment for this or other issues
Initial

____ I am **not** currently being visited by a Home Health Agency.
Initial

I understand the enforcements Medicare has put into place regarding Therapy Services.

_____ _____

**Patient's Signature** **Date**

**GRELOT PHYSICAL THERAPY MEDICAL HISTORY FORM**

Name:_____Age:_____Occupation: _____

Currently Working? Yes / No_____hours/week Student? Yes / No: Where:_____

What brings you to physical therapy?_____

What do you hope to achieve by coming to physical therapy?_____

Date of onset/injury: _____Date of surgery: _____

Have you had treatment from a medical practitioner? _____Describe:_____

Did that treatment help? _____Explain:_____

Next appointment with practitioner who referred you to physical therapy? _____

What tests have you had for this problem? __X-ray __Bone __Scan __ MRI __ EMG __ CT Scan ____

Where were tests done? _____

What were the results? _____

Are you currently receiving any other medical/health services? _____

Since it started, the pain is: getting worse improving the same

Describe the pain: sharp dull aching burning throbbing shooting cramping stabbing __sore other _____

Check any activities you have difficulty with due to the problem for which you are seeking treatment:

| | | | |
|---|---|---|---|
| ☐ sleeping | ☐ rising from a chair | ☐ bathing | ☐ getting in/out of bed |
| ☐ dressing | ☐ driving | ☐ using | ☐ light housekeeping |
| ☐ standing | ☐ self-care | ☐ sitting | ☐ getting in/out of vehicle |
| ☐ grasping | ☐ meal preparation | ☐ eating | ☐ reaching to shelves |
| ☐ lying flat | ☐ rolling over | ☐ talking | ☐ bending/stooping |
| ☐ balancing | ☐ kneeling | ☐ chewing | ☐ walking short distance |
| ☐ jumping | ☐ running | ☐ biting | ☐ walking long distance |
| ☐ pulling | ☐ reaching | ☐ hopping | ☐ walking outdoors |
| ☐ lifting | ☐ carrying | ☐ squatting | ☐ pushing |

My leisure activities/sports: _____

My job responsibilities: _____

Other difficulties:_____

Please consider your average pain over the last 5 days, and mark an X on the line below:

1——————————————————————1

No Pain at all — Severe enough for the hospital

_____ Patient's Initials

# GRELOT PHYSICAL THERAPY MEDICAL HISTORY FORM

Have you been discharged from a hospital or skilled nursing facility in the last 30 days? _____

How many times have you fallen in the past 2 years? _____If so, what happened?_____

Allergies: None___ Latex___ Tape/Adhesives___ other:_____

How would you rate your current health? Excellent___ Very Good___ Good___ Fair___ Poor___

Please check if you have any or a history of the following conditions:

___Smoke/Chew Tobacco
Packs per day: _____
___Use of Illegal Substances
___Drink Alcoholic Beverages
Amount per day: _____
___High Blood Pressure
___High Cholesterol
___Bowel/Bladder problems
___Acid Reflux or Ulcers
___Thyroid Disorder
___Bleeding Disorder
___Seizures/Epilepsy
___Fractures
___Head Trauma
___Sleeping Difficulties
___Heart Condition: _____

___Diabetes
___Heart Attack
___Cardiac Bypass
___Cardiac Stents
___Angina/Chest Pain
___Pacemaker
___Emphysema
___COPD
___Asthma
___Kidney Disease
___Stroke
___Depression
___Respiratory illness
___Convulsions
___Rheumatic disease
___Other: _____

___Sexually Transmitted Disease
___Osteoarthritis
___Rheumatoid Arthritis
___Osteoporosis or Osteopenia
___Metal/Plastic Implants
___Headaches or Migraines
___Dizziness or Fainting
___Cancer (site: _____)
___Recent Infection
___Hernia
___Recent Antibacterial Medicine Use
___Consistent Steroidal Medicine Use
___Blood disease
___Vascular disease
___Women: I am pregnant.

List all previous surgeries and dates: _____
_____

List all medications/supplements you are taking: _____
_____

List any other Physical or Personal limitations: _____
_____

To the best of my knowledge, the information provided herein is correct.

_____ _____

Patient/Representative Date