9605 Jefferson Hwy Suite I
River Ridge, LA 70123
Phone: 504-603-6044
Fax: 504-613-4617
Email: riverbendpt@gmail.com

Patient Registration Form

Please provide the following information:

Patient Information:

First Name: _____

Last Name: _____ MI: _____

Date of Birth: _____ Age: _____

Marital Status: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Home Phone: _____

Cell Phone: _____ Work Phone: _____

Emergency Contact Information:

Emergency Contact Name: _____

Phone: _____ Relationship: _____

Referral Information:

Primary Care Physician: _____

Location (City, State): _____

Referring Physician: _____

Location (City, State): _____

How did you hear about us?: _____

Insurance Information: (If we have your info, you do not have to fill this out)

Primary Insurance Company: _____

Policy Number: _____

Group Number: _____

Main Policy Holder Name: _____

Date of Birth: _____

Secondary Insurance Company: _____

Policy Number: _____

Group Number: _____

Main Policy Holder Name: _____

Date of Birth: _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I confirm that all information provided above is accurate to the best of my knowledge. I authorize Facility Name to release any of my medical information necessary to process claims.

Patient Signature

Print Name

_____

Date

_____

Health History Questionnaire

Welcome to Riverbend Physical Therapy! Please take a few minutes to let us know why you are here as this will help us develop a treatment plan for you that will meet your individual needs. If you have any questions as to how to complete this form, please leave that section blank and ask the therapist for help.

Pain Scale

(1 thru 10) 0=None 5=Moderate 10=Extreme

Current _____ Best_____ Worst_____

Description of Pain – Circle all that apply

Burning	Numbness	Tingling
Constant	Sharp	Worst At Night
Dull / Achy	Shooting	Worst In Morning
Intermittent	Throbbing	
Other		

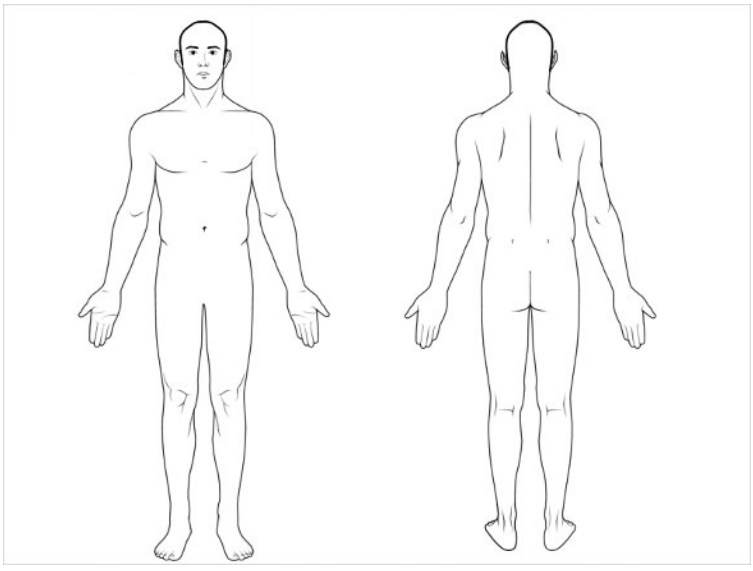
Aggravating Issues – Circle all that apply

Bending	Sit or Stand	Walking
Coughing	Sneezing	Swimming
Laying Down	Standing	Stairs Down
Sexual Intercourse	Voiding	Stairs Up
Other		

Type of Injury – Circle all that apply

Auto Accident	Post Surgical	Insidious(gradual onset)
Re-injury	New Injury	Work-Related Injury
Non-Specific	Sports Injury	Non Work-Related
Reoccurance of Pre-Existing Injury		
Other		

On the diagram below, please mark where you have pain, numbness, or tingling.



General Health Status – Circle one of the following

Excellent Good Fair Poor

Other

Treatments Related to Condition List Below

Current Functional Limitations List Below (e.g. self care, walking, stairs, reaching)

_____

_____

Social / Health Habits – Circle all that apply

Smoking

Does not currently smoke tobacco.

Does curently smoke tobacco.

How many packs per day?

How many cigars / pipes per day? ____

Smoked in the past.

Year Quit: _____

Alcohol

How many days per week do you drink beer, wine or alcholic beverages, on average?

_____

If one beer, one wine or one cocktail equals one drink, how many drinks do you have on an average day?

_____

Exercise

Do you exercise beyond normal daily actvities and chores?

Yes No

Describe the exercise: _____

On average how many days?

Stats

Age _____

Height _____

Weight _____

Medical / Surgical History – Circle all that apply

Allergies	Kidney Problems	Infectious Disease
Athritis	Lung Problems	Other: (list below)
Blood Disorders	Multiple Sclerosis	
Broken Bones	Muscular Dystrophy	
Cancer	Osteoarthritis	
Cardio Vascular Disease	Osteoporosis	
Circulation / Vascular	Parkinson's Disease	
Diabetes	Psyco - Social	
Denies PMH	Repeated Infections	
Depression	Seizures / Epilepsy	
Developmental Problems	Skin Disease	
Head Injury	Stroke	
Heart Problems	Surgeries	
High Blood Pressure	Thyroid Problems	
Hypoglycemia	Ulcers / Stomach Problems	

History of Falls in the past year? No Yes

If yes, number of falls in past year _____

Medical Symptoms in Past year

Bowel Problems	Hoarseness
Chest Pains	Joint Pain or Swelling
Coordination Problems	Loss of Appetite
Cough	Loss of Balance
Difficulty Sleeping	Nausea / Vomiting
Difficulty Swallowing	Pain at Night
Difficulty Walking	Shortness of Breath
Dizziness / Blackouts	Urinary Problems
Fever / Chills / Sweats	Vision Problems
Headaches	Weakness in Arms or Legs
Hearing Problems	Weight Loss / Gain
Heart Palpitations	Pregnancy
Other	

Current Medications

None	Dietary Supplements
Advil	Epidural
Aleve	Herbal Supplements
Antacids	Ibuprofen
Antihistamines	Naproxen
Aspirin	Over the Counter
Cortisone Injection	Prescription
Decongestants	Tylenol
Other	

Occupational Status

Full-time - From Home	Part-time - From Home
Full-time - Outside of Home	Part-time - Outside of Home
Homemaker	Retired
Light Duty	Student
Not Working	Unemployed
Other	

Job description: _____

Is the problem/injury you are being treated for related to a work injury? _____

If yes, when was injury

Is your problem/injury currently under litigation? _____

Patient Signature

_____

Print Name

_____

Date

_____

RIVERBEND
PHYSICAL THERAPY

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Financial Policy

Thank you for choosing Riverbend Physical Therapy as your health care provider. We are sincerely committed to providing you with a successful and pleasurable treatment experience. Please understand that payment of your bill is considered part of your treatment and that this financial policy obligates you to provide full payment of your bill. All patients are required to establish financial arrangement for payment of their account and complete all provided forms before they are treated by our staff. As a courtesy, we will verify your insurance coverage and bill your insurance provider on your behalf. However, please understand that your insurance policy is a contract between you and your insurance provider. **You are responsible for any outstanding balances that are not covered by your insurance provider.**

Patient Insurance: We require your co-payment and/or deductible payment at the time of treatment. In the event that your insurance changes to a plan in which Riverbend Physical Therapy is not a participating provider, you will be responsible for the full amount that is billed for your services. Riverbend Physical Therapy will

not become involved in any disputes between you and your insurance provider regarding deductibles, co-payments, covered charges, "usual and customary" charges other than to supply factual information as requested.

If you receive payment from your insurance provider for services rendered by Riverbend Physical Therapy, you are required to reimburse Riverbend Physical Therapy the full payment amount at the time of receipt. If you default on any balance owed to Riverbend Physical Therapy and it becomes necessary for Riverbend Physical Therapy to engage the services of an attorney, collection agency or other lawful method of collection, you will be responsible for the original balance owed and reimburse Riverbend Physical Therapy for all costs incurred by it in the collection of said debt. I am allowing a photocopy of my signature to be used for insurance purposes. I also authorize my insurance company to pay directly to Riverbend Physical Therapy the amount due me in my pending claim for insurance.

Missed Appointments: Our policy is to charge $25.00 for any missed appointments that are not cancelled at least 24 hours in advance and this fee will become the responsibility of the patient and not billed to your insurance provider.

Late Fee: A $15.00 per month late fee is assessed on all unpaid patient responsibility balances that are greater than 30 days.

Minors: The parent or guardian accompanying a minor is responsible for payment.

Auto Insurance: We will submit claims to your MedPay with your auto insurance. If you do not have MedPay, we will submit claims to your health insurance. Facility Name does not accept letters of protection.

Consent to Treat and Authorization to Release Information: I hereby authorize Riverbend Physical Therapy, through its appropriate personnel, to perform the evaluation and treatment procedures that are deemed necessary by my physician and physical therapist in the treatment of my condition. I further authorize Riverbend Physical Therapy to furnish and/or disclose my personally identifiable health information to the appropriate agencies for the purpose of billing.

I have had the opportunity to review the Riverbend Physical Therapy Privacy Notice prior to signing this consent. I understand that I have the right to request restrictions on the uses and disclosures of my protected health information for treatment, payment and healthcare operations, but Riverbend Physical Therapy is not required to agree to such a request. If Riverbend Physical Therapy does agree to my request, the restrictions will be binding.

I have read the above Financial Policy and agree that I am responsible for the balance of my account for any professional services rendered by Riverbend Physical Therapy.

Patient Signature

Print Name

Date

_____

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INSURANCE BILLING:

We will gladly call your insurance company to identify your current benefit coverage. However, please understand that insurance companies will not guarantee medical benefits over the phone. We can only use this information as an estimate guideline. Actual determination is made after we receive written notification and/or payments on your claim. We strongly encourage you to contract your insurance company directly in order to understand your plan's coverage and limitations. If your insurance carrier denies any part of your claim or if you or your physician elects to continue therapy past your approved period, you will be responsible for your account balance in full.

WORKER'S COMPENSATION:

We strive to work with physicians, employers, adjusters and nurse case managers to provide the best quality care necessary to restore your optimal rehabilitation potential. All insurance carriers require a prior approval of treatment before services can be rendered. It is your responsibility as the claimant to provide our office with all pertinent contacting information. Please be prepared to provide us with names of the insurance carrier, adjuster, nurse case manager, attorney, telephone and fax numbers, date of injury, surgery date, and claim number.

PAYMENTS:

All deductibles, co-pays, co-insurance and cash pay amounts are due at the time of service, unless other written arrangements are made with our facility.

Any unpaid balance on your account after 120 days without financial arrangements may be subject to legal collection proceedings and a 35% collection fee will be added to your outstanding bill. Please do not hesitate to ask us any questions or request a copy of your account balance.

PATIENT RIGHTS & GRIEVANCE:

Patients utilizing rehabilitation services are entitled to:

- Licensed/ certified clinicians to evaluate all admissions and if deemed necessary and reasonable, initiate an appropriate plan of treatment under the order of the physician.
- A clean, safe, healthy environment and proper infection control procedures as determined by clinical guidelines.
- Assessment of functional levels using appropriate evaluative techniques.
- Protection of privacy and confidentiality.
- Patient teaching and/or family education as each individualized treatment process for his/her admission through discharge.
- Inclusion of the patient and patient's family in the physical setting, expectations, outcomes, treatment programs and scheduled therapy services.
- Be treated with consideration, respect, and full recognition of dignity and individuality.
- Voice grievances regarding treatment of care that is (or fails to be) furnished or regarding the lack of respect by anyone furnishing services and must not be subjected to discrimination or

reprisal for doing so. Grievances may be reported to the client relations specialist or clinical director.

Again, we appreciate your choosing Riverbend Physical Therapy.

CERTIFICATION:

By signing this form, I the patient (or legal guardian of the patient), have read, understand and agree that I am 100% responsible for all fees incurred at Riverbend Physical Therapy, attendance policy, rights and grievance, and HIPAA privacy notice. I agree to authorize Riverbend Physical Therapy to release my medical information to insurance companies, physicians, nurse case managers, attorneys and to all other pertinent parties that may be involved in my claim or care. I also agree to assign benefits to Riverbend Physical Therapy.

Patient Signature

Print Name

_____

Date

_____

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HIPAA Privacy Policy

It is the policy of Riverbend Physical Therapy that all providers and staff preserve the integrity and the confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice and its providers and staff have the necessary medical and PHI to provide the highest quality physical therapy care possible while protecting the confidentiality of the PHI of our patients to the highest degree possible. Patients should be confident to provide information to our practice and its providers and staff for purposes of treatment, payment and healthcare operations (TPO), knowing that our practice and its providers and staff will:

- Adhere to the standards set forth in the Notice of Privacy Practices.
- Collect, use and disclose PHI only in conformance with state and federal laws and

  current patient covenants and/or authorizations, as appropriate. Our practice and its providers and staff will not use or disclose PHI for uses outside of practice's TPO, such as marketing, employment, life insurance applications, etc. without an authorization from the patient.

- Use and disclose PHI to remind patients of their appointments only with their consent.
- Recognize that PHI collected about patients must be accurate, timely, complete, and available when needed. Our practice and its providers and staff will:
- Implement reasonable measures to protect the integrity of all PHI maintained about patients.
- Recognize that patients have a right to privacy. Our practice and its providers and staff respect the patient's individual dignity at all times. Our practice and its providers and staff will respect patient's privacy to the extent consistent with providing the highest quality medical care possible and with the efficient administration of the facility.
- Act as responsible information stewards and treat all PHI as sensitive and confidential. Consequently, our practice and its providers and staff will:
- Treat all PHI data as confidential in accordance with professional ethics, accreditation standards, and legal requirements.

- Not disclose PHI data unless the patient (or his or her authorized representative) has properly consented to or authorized the release or the release is otherwise authorized by law.
- Recognize that, although our practice "owns" the medical record, the patient has a right to inspect and obtain a copy of his/her PHI. In addition, patients have a right to request an amendment to his/her medical record if he/she believe

his/her information is inaccurate or incomplete. Our practice and its providers

and staff will--

- Permit patients access to their medical records when their written requests are

  approved by our practice. If we deny their request, then we must inform the patients that they may request a review of our denial. In such cases, we will have an on-site healthcare professional review the patients' appeals.

- Provide patients an opportunity to request the correction of inaccurate or incomplete PHI in their medical records in accordance with the law and professional standards.
- All providers and staff of our practice will maintain a list of all disclosures of PHI for purposes other than TPO for each patient. We will provide this list to patients upon request, so long as their requests are in writing.
- All providers and staff of our practice will adhere to any restrictions concerning the use or disclosure of PHI that patients have requested and have been approved by our practice.
- All providers and staff of our practice must adhere to this policy. Our practice will not tolerate violations of this policy. Violation of this policy is grounds for disciplinary action, up to and including termination of employment and criminal or professional sanctions in accordance with our practice's personnel rules and regulations.
- Our practice may change this privacy policy in the future. Any changes will be effective upon the release of a revised privacy policy and will be made available to patients upon request.

Patient Signature

_____

Print Name

_____

Date

_____

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Physical Therapy Consent Form

I hereby consent to evaluation and/or treatment of my condition by licensed physical therapist employed by or under contract with Riverbend Physical Therapy. The physical therapist has fully explained to me the nature and purposes of the procedures, evaluation and course of treatment, and has witnessed my signature of this consent in his or her presence.

The physical therapist has informed me of expected benefits and possible complications or discomfort, which may result from skilled physical therapy care. The physical therapist has also reviewed the risks of receiving no treatment.

The physical therapist has explained that there is not guarantee that the planned course of treatment will improve my condition and although unlikely, it is possible that the course of treatment may cause additional pain, discomfort and/or aggravation to my condition.

I have been given the opportunity to ask questions, and all my questions have been answered to my satisfaction. I confirm that I have read and fully understand this consent form.

Patient Signature

_____

Print name

_____

Date

_____