CITY PARK LLC
PHYSICAL THERAPY

Patient # _____

Please Print and Answer All Questions

Date: _____

Last Name: _____ First Name:_____Middle Initial _____ Sex: M / F
Address: _____ City: _____ State: _____ Zip: _____
Home Phone:_____ Work Phone: _____ Cell Phone: _____
Birth Date: _____ Age: _____ Marital Status: Single Married Divorced Widowed
S.S. #: _____-_____-_____ Driver's License # and State: _____
Email Address: _____
What is the best way to contact you to remind you of your treatment schedule?
Please circle: Text Message Phone Call
Employment Status (Please Circle): Employed (full / part) Unemployed Retired Student Homemaker
Employed By: _____ Occupation:_____
Address: _____ City:_____ State:_____ Zip:_____
If unemployed, is it due to your injuries? If yes, please explain.
_____.
How were you referred to our office?_____
Person to contact in case of emergency: _____
Phone #: _____ Relation: _____

Health Insurance:
Name of Insurance Carrier: _____
Policy #: _____ Group #: _____
Insured: _____ Relationship of Insured: _____
SSN of Insured **OTHER THAN SELF**:_____ **DOB**:_____
Are you covered under any other group or individual health policy: _____ Yes _____No
If so, what's the name of the company: _____ Policy: _____

Please select one of the following payment options:
____ HEALTH INSURANCE – payment of unmet deductible and patient co-pay or coinsurance each visit
____ SELF PAY-- payment in full at each visit. Do not file with insurance.
____*AUTO ACCIDENT
____*WORKERS COMPENSATION
____*ATTORNEY
____*OTHER THIRD PARTY LIABILITY
*For auto, workers compensation, attorney, and/or other third party liability cases, we will also need your individual or group health insurance.

I certify that any and all information given is true and correct. I hereby authorize the release of any information required by this office. I also assign my benefit payments to be made directly to this clinic. I understand that I am financially responsible for all services rendered. Appointment reminders will be sent to a mobile device as a text message, to an email address, or as a phone call, depending on your preference. City Park Physical Therapy assumes no liability for fees that result from text messages. I give City Park Physical Therapy permission to contact me to remind me of my treatment schedule.

Signature: _____ Date:_____

History of the Symptoms For Which You Are Seeking Treatment:
Briefly describe your symptoms:

_____

_____

When and how did the symptoms begin?

_____

_____

_____

Do any of the following increase your symptoms: Please Circle.
Sitting Standing Lying Down Lifting Other_____

The pain is more severe during: ____Morning ____ Afternoon ____Evening ____All Day
Are there any modalities that relieve your pain? (Ex: Ice, Heat, Medication, Rest, Etc.)

_____

Physician who sent you_____

Past Medical History:
Surgeries:_____

_____

Fractures:_____

_____

Serious Illness:

_____

_____

Worker's Comp. / Personal Injuries :) _____

_____

Sports, military or other injuries to head, neck or back: _____

_____

	None	Light	Moderate	Heavy
Exercise				
Smoke				
Drink Alcohol				
Experience Stress				

Current Weight: _____ Height: _____ Please Circle: Right Handed / Left Handed
Any history of high blood pressure?_____

List any & all medications (include over-the-counter):
Name & How Often Taken:

_____
_____
_____
_____

List any known/suspected allergies:

_____
_____

Family History:
Is there a significant history of any of the following in your blood relatives?
Diabetes / Stroke / Cancer / Heart Condition / High Blood Pressure / Other: _____

Who?_____

Home Health:
Have you received any home health in the last 2 months? ___Y___N
If Yes, what is the name of the agency? _____ Discharge Date: _____

If patient is 26 years of age or under or is a full-time student, please complete:

Father's name: _____ SSN_____ DOB_____
Employer _____ Work Phone _____

If Address is the same as above please check _____ If different please continue to fill out:
Address _____ City _____ State _____ Zip _____

Mother's Name: _____ SSN _____ DOB_____
Employer _____ Work Phone _____

If Address is the same as above please check _____ If different please continue to fill out:
Address _____ City _____ State _____ Zip _____

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AUTHORIZATION OF TREATMENT, ASSIGNMENT OF BENEFITS, AND RESPONSIBILITY

I authorize the medical treatment, which has been or will be provided to me or my dependent, as named above, by City Park Physical Therapy, L.L.C., and that I am the responsible party for any such charges incurred. Should I elect to have City Park Physical Therapy, L.L.C. file my insurance, I realized I am financially responsible for my deductible, co-pay or coinsurance for the deductible, co-pay or coinsurance for my dependent child. I understand that if at any time during my treatment or my dependent's treatment my insurance coverage lapses or is terminated I am financially responsible for charges incurred. I agree to be responsible for any reasonable collection costs and/or attorney's fees incurred in the collection of my or my dependent's account if this should be necessary. In consideration of medical services rendered by City Park Physical Therapy, L.L.C., I hereby assign, transfer, and set over to City Park Physical Therapy, L.L.C. all of my rights, title, and interest to medical reimbursement. I also authorize the release of medical and/or billing information necessary to process claims.

_____ _____

Signature – Must be 18 or older Date

_____ _____

Signature of Policy Holder Signature of Witness

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name	Date of Birth	Social Security Number
Patient Address	City, State, Zip Code	Home/Work Telephone

I , or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with Louisiana State law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV RELATED INFORMATION only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information of the person(s) indicated in Item 8.
2. If I am authorized the release of HIV-related, alcohol or drug treatment, or mental health information, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal and state law. I understand I have the right to request a list of people who may receive or use my HIV-related information without my authorization. If I experience discrimination because of the release of disclosure of HIV-related information, I may contact the Louisiana Commission of Human Rights at (225) 342-6969. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on my authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in the health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be re-disclosed by the recipient (except as noted above in item 2) and this re-disclosure may no longer be protected by federal or state law.
6. THIS AUTHORAIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THAT ATTORNEY, GOVERNMENT AGENCY OR PERSON SPECIFIED IN ITEM 9(b).
7. Name and address of health provider or entity to release this information: CITY PARK PHYSICAL THERAPY
8. Name and address of health provider or entity to which this information will be sent: CITY PARK PHYSICAL THERAPY L.L.C., 5559 CANAL BLVD., NEW ORLEANS, LA 70124. PHONE (504)-309-5811 FAX (504)-309-5877.
9. (a) Specific information to be released:
   __ Medical Record from (insert date) _____ to (insert date) _____.

Please check BOX:

__ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to other health care providers.

AUTHORIZATION TO DISCUSS HEALTH INFORMATION

9. (b). By initialing here _____ I authorize City Park Physical Therapy, L.L.C. to discuss my health information with my attorney, a governmental agency or the person(s) listed here:_____.

10. Reason for release of information: _____ At the request of individual _____ Other: _____

11. Date or event on which this authorization will expire: _____

12. If not the patient, name of person signing form (print):_____

13. Authority to sign on behalf of patient (relationship/print): _____

All items on this form have been completed and my questions about this form have been answered. In additions, I have been provided a copy of this form.

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If I _____,receive any checks from my insurance company for any therapy received, I agree to bring said check(s) to City Park Physical Therapy OR I agree to pay FULL BILL CHARGES.

_____ _____

Patient/Guarantor Signature Patient/Guarantor Name Printed

_____

Date