BABINPT
PHYSICAL THERAPY
BETTER QUALITY OF LIFE

PATIENT INFORMATION

Name_____ Birthdate_____ Age_____ SS#_____

Address_____
Street City State Zip

Home Phone_____ Cell Phone_____ Email_____

Marital Status: Single Married Divorced Widowed Other Occupation: _____

Emergency Contact_____ Phone #_____ Relationship_____

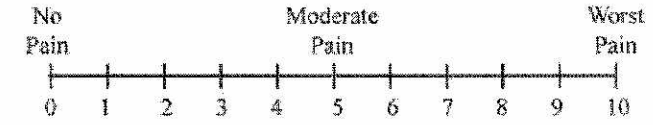
How did you hear about our clinic?

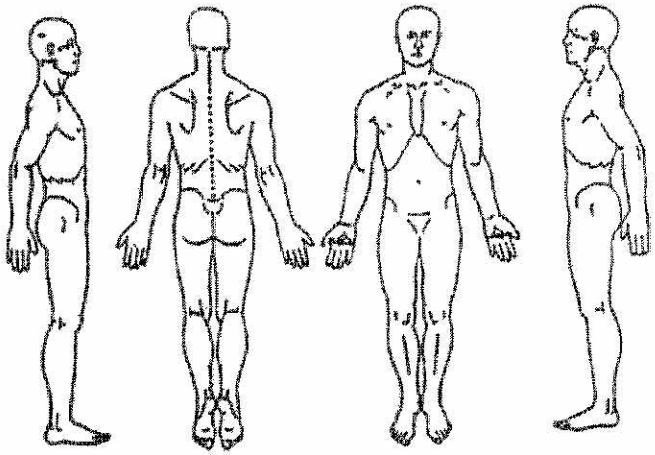
☐ My doctor's office ☐ I am a former patient ☐ Family/friend/colleague recommended ☐ My insurance company said you were in my network ☐ I did a search on the internet ☐ My trainer ☐ Other_____

Please tell us who we can thank for sending you our way:_____

REVIEW OF SYMPTOMS

With a highlighter, please mark how intense your pain has been on the scale below. Then, indicate where you have symptoms or pain on the body model.





How often do you experience your symptoms?

1. Constantly (76-100% of the day)
2. Frequently (51-75% of the day)
3. Occasionally (26-50%)
4. Intermittently (0-25%)
5. No Symptoms

What describes your Pain?

1. Sharp
2. Dull
3. Numb
4. Shooting
5. Burning
6. Tingling
7. N/A

How are your symptoms changing?

1. Getting Better 2. Not Changing 3. Getting Worse

Please describe the problem / condition that brought you to therapy:

_____

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How did your problem / condition begin? (Circle one): Date your condition began: _____

Injury Sudden Onset Gradually Post Operation Motor Vehicle Accident Other: _____

Who have you seen for your symptoms? (Circle all that apply):

No One Medical Doctor Chiropractor Home Health Massage Therapist PT Other: _____

What are you most hoping to get out of your therapy / activities you would like to return to:

_____

Do you now or have you ever had any of the following? (Circle all that apply) NONE APPLY

Asthma, Bronchitis, or Emphysema High Blood Pressure Anemia Shortness of Breath/Chest Pain

Heart Attack or Surgery Diabetes Coronary Heart Disease or Angina Thyroid Trouble/Goiter

Gout Cancer/chemotherapy/Radiation Dizziness or Fainting Weakness Mental Health Problems

Infectious Diseases Hernia Bowel or Bladder Problems Allergies Severe or Frequent Headaches

Elbow/Hand Injury Osteoporosis Vision or Hearing Difficulties Neck Injury/Surgery Stroke/TIA

Sleeping Problems/Difficulties Back Injury/Surgery Blood Clot/Emboli Leg/Ankle/Foot Injury/Surgery

Knee Injury/Surgery Epilepsy/Seizures Arthritis/Swollen Joints Varicose Veins Joint Replacement

Do you have a Pacemaker? YES/NO **Any Pins or Metal Implants?** YES/NO **Do You Smoke?** YES/NO
Females: **Are You Pregnant?** YES/NO
Explanations (If needed): _____

SURGERIES (LIST PROCEDURE AND YEAR):
Body Region:_____ Surgery Type: _____ Date:_____
Body Region:_____ Surgery Type: _____ Date:_____
Body Region:_____ Surgery Type: _____ Date:_____

Are you currently taking any medications? Y / N If yes: Is list attached Y/N OR please list below:
Medication_____ Dosage_____ Reason for taking: _____
Medication_____ Dosage_____ Reason for taking: _____
Medication_____ Dosage_____ Reason for taking _____
Allergies (Medications and Others): _____

I acknowledge that the above information is true and correct. I hereby authorize treatment and understand the possible benefits and risks of my treatment. I irrevocably assign all benefits to Babin Physical Therapy. I authorize release of any medical records to my doctor, insurance company, attorney, claims adjuster and my employer. I also authorize release of any physician or medical facility to release information relevant to Babin Physical therapy. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any professional services. I further understand and agree to pay for all fees incurred should this bill be turned over to an agency or attorney for collection.

Signature_____ Date_____

FINANCIAL POLICY BABIN PHYSICAL THERAPY

We are committed to providing you with the best in Therapy care. In order to do this without comprising our patients; this policy has been implemented for each patient. If you have medical insurance, we are anxious to assist you in receiving your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy. **Payment for services is due at the time services are rendered unless other acceptable and agreed upon arrangements have been approved in advance by our staff. We accept cash, checks, and credit cards.**

MEDICAL INSURANCE INFORMATION

Primary Insurance Company_____ Member ID#_____

Primary Insured _____ (if other than patient) Relationship to patient_____ Primary Insured DOB_____

Secondary Insurance_____ (if applicable) Policy ID #_____

Secondary Insured _____Relationship to patient_____ Secondary Insured DOB_____

□**Copay Applies:**
Your copay is $_____. We will collect this amount at each visit.

□**Deductible Applies:**
Your deductible is $_____ and $_____ has been met. We will collect $_____each visit to be applied toward your deductible. This amount can be adjusted when the exact amount of your responsibility has been determined, once the claim is processed.

□**Co-insurance Applies:**
If you are required to pay a co-insurance percentage, we will collect $_____ each visit as an estimate of your co-insurance amount. This amount can be adjusted when the exact amount of your co-insurance has been determined, once the claim is processed.

□**Secondary Insurance will be filed**. Should your secondary insurance not cover any copay, deductible or co-insurance, you will be billed the amount applied as patient responsibility from your primary insurance.

We must emphasize that as a Medical provider, our relationship is with you, not your insurance company. While the filing of an insurance claim is a courtesy that we extend to our patients, all charges are your responsibility from the date the services were rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. If you have any questions about the above policy or any uncertainty regarding your insurance coverage, PLEASE don't hesitate to ask us.
Please be further advised that returned checks and balances older than 30 days from your treatment discharge may be subject to additional collection and legal fees, as well as, interest charges of 1.6% per month. Please be advised, any unpaid balanced billed after 120 days will be turned over for collections to Southern Credit Recovery, located at 3228 6th Street, Metairie, LA 70002, phone (504) 841-2000.

_____ _____
Signature of Patient/Guarantor Date

_____ _____
Signature of BabinPT Representative Date

File Name: Financial Policy as of 05/2019

BABIN PHYSICAL THERAPY
371 WEST ESPLANADE AVE
KENNER, LA 70065

Patient Consent for Use and/or disclosure of Protected Health Information

1. I understand that as part of my health care treatment, **Babin Physical Therapy** develops and maintains records containing my health information, which includes information about my health history, symptoms, test results, diagnosis, treatment, claims, and payment history, etc. I understand that my health information will be used and disclosed by **Babin Physical Therapy** for treatment, payment and health care options and serves as:

   - a basis for planning my care and treatment
   - a means of communicating among health professionals who may contribute to my care
   - a source of information to bill for health care services rendered
   - a means by which an insurance company or other third party payor can verify that services billed were actually provided; and
   - a resource for "health care operations," such as assessing quality of care and reviewing the competence of health care professionals.

2. I have been provided with **Babin Physical Therapy's** Privacy Notice which provides a more complete description of the use and disclosure of my health information. I understand that I have the right to review the Privacy Notice prior to signing this consent form. I understand that **Babin Physical Therapy** can change the terms of the Privacy Notice. **Babin Physical Therapy** reserves the right to make the new Privacy Notice provisions effective for my health information that it already maintains and uses, as well as for any health information that it may receive in the future.

3. I understand that if I refuse to sign this Consent, **Babin Physical Therapy** may refuse treatment.

4. I understand that I have the right to request that **Babin Physical Therapy** restrict how my health information is used or disclosed to carry out treatment, payment or health care operations, but such request may not be accepted. I request the following restrictions (N/A if no restrictions)

   _____

5. I understand that I may revoke this Consent at any time by notifying **Babin Physical Therapy** in writing, but if I do, it will not have any effect on uses or disclosures prior to the receipt of the revocation.

_____ _____

Patient Signature Date

_____

Babin Physical Therapy Representative

PATIENT MISSED APPOINTMENT POLICY

Our patients' adherence to the recommended number of treatments is a vital component of their Plan of Care. Therefore, we have certain rules that need to be followed in order to ensure optimum results from therapy.

We expect our patients to keep all of their appointments and, in rare instances, perform make up visits should they have to cancel.

With the exception of rare emergencies it is expected that all patients will keep their appointments. If you need to re-schedule an appointment we require a 24 hour notice. In such a case, please call our office and arrange for a make-up appointment with our Front Desk Coordinator. The make-up appointment needs to be in the same week, preferably the next day.

In the instance of a cancellation, without 24 hour notice, we reserve the right to charge the patient a $25.00 fee. In the instance of a no-show you may be charged a $50.00 fee.

If the patient is repeatedly non-compliant with scheduled visits, we also reserve the right to discontinue care and will inform the referring physician of the discontinued Plan of Care due to non-compliance with the prescribed rehab order.

We appreciate you greatly as our patient and strive to accomplish wonderful results and success for you.

Babin Physical Therapy Services, Inc.

I have read and understood this policy.

Signature_____

Date_____