Michael Jacketta, DPT, OCS

**** Please Provide a copy of your ID and Insurance Card with this Paperwork****

Patient Information:

Name:____Social Security#: __________________

Date of Birth: __________Age:_______Sex (Circle): M F Marital Status (Circle): S M D W

Physical Address: ______________________________ City: ______________ State: ____ Zip: _______

Mailing Address: _______________________________City: ______________ State: _____ Zip: ______

Home Phone: ____________________Cell Phone: ________________ Email____________________

How would you like to receive Appointment Reminders? EMAIL or TEXT

Please list your cell phone provider: ___________

Employer: ______________________________ Full time/Part time Work Phone: _________________

Occupation:____

Responsible party for anyone under 18: ______________________Relationship to Patient: _____________

Emergency Contact: _______________________Emergency Contact Phone Number: ________________

Referring Physician: ____

Have you been under Home Health Care in the last month? ______If yes, please Specify _________________

How did you learn about this facility? Check all the places that you have seen our company please:

□ Physician □ Home Health □ Insurance Company □ Telephone Book □ Newspaper

□ Website □ Social Media □ Google

□ You are a Former Patient □ Family/Friend (Who we can thank for your business!) ____________________

Injury Information:

When did your current condition begin? Month:_______Date:________Year:_________ Surgery Date:_________

Is this a Worker's Compensation injury? ________Yes ______No Date of Injury ______________

Is this due to an Automobile Accident? ________ Yes ______No Date of Accident ______________

Are you working with a lawyer for this injury/condition? ____ Yes ____ No Name of Lawyer ______________

Are you currently: (Please check One)
_____a. Working at your usual job without restrictions _____b. Working at your usual job with restrictions
_____c. Retired/unemployed ______d. Unable to work because of other medical reasons
_____e. Unable to work because of your condition

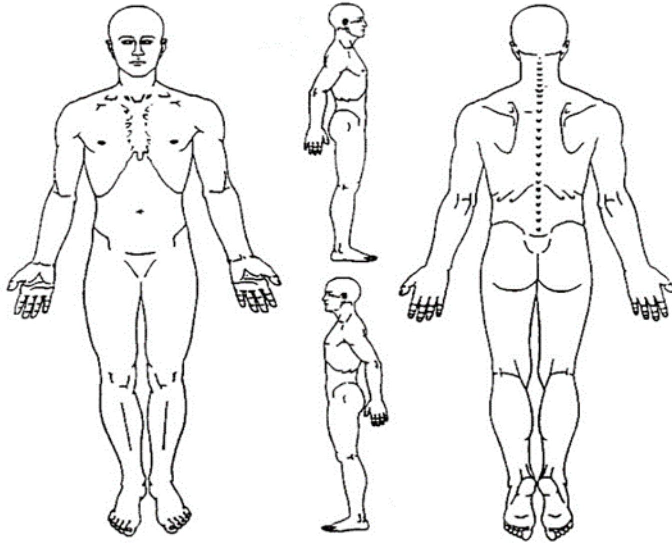
What originally caused your current symptoms? (Please check one)
_____a. Not sure of the cause _____b. Fall/Slip _____c. Motor Vehicle accident _____d. Bent/twist
_____e. Cough/Sneeze _____f. Lifting _____g. Yard Work _____h. Athletic Activity _____i. Shoveling snow
_____j. Other __________

Have you had: _____ X-rays _____MRI _____ CT Scan _____ Other Diagnosis _____ Other Studies

How many falls have you had in the last year? __________ Did an injury occur with any falls?___Yes ____No

FOR WOMEN: Are you currently pregnant or think you might be pregnant? ______ Yes ______ No

Please indicate where your pain in located:



Circle location of injury:

Place //// on location if any sharp pain

Place xxx on location if any burning pain

Place \\\\ on location if any aching

PAIN INTENSITY: Currently 0-10 __________ At its Worst 0-10__________ At its Best 0-10 _________

0= No Pain 10= Emergency Room

What is your current height? __________ **What is your current weight**? __________

Medical History:

Have you recently had any of the following?

YES NO Weight Gain/Loss
YES NO Fatigue
YES NO Fever/Chills/Sweats
YES NO Depression
YES NO Nausea/ Vomiting
YES NO Weakness
YES NO Numbness or Tingling

ALLERGIES: List any medication(s) you are allergic to: ____

Are you latex sensitive? _____ Yes _____ No

List any other allergies we should know about: ____

Have you declared the Advanced Clinical Directive or Do Not Resuscitate? _____ Yes _____ No

Please check any of the following whose care you are under:
_____Medical Doctor (MD) _____Psychiatrist/Psychologist _____Osteopath _____Dentist _____Chiropractor
_____Other: ______________

If you have seen any of the above during the past three months, please describe for what reason (illness, medical condition, physical,
etc.):____

How much caffeinated coffee or caffeine containing beverages do you drink per day? ________________________

Do you use cigarettes or smokeless tobacco, if yes, how much per day? ________________________

How many days a week do you drink alcohol? ________________________

If one drink equals one beer or glass of wine, how much do you drink at an evening sitting? ____________

How many days per- week do you use mind altering substances not prescribed by a physician? ____________

Have **YOU EVER** been diagnosed as having any of the following conditions?

YES NO Cancer-IF yes, describe what kind: __________
YES NO High Blood Pressure
YES NO Asthma
YES NO Chemical Dependency (i.e., alcoholism)
YES NO Diabetes
YES NO Rheumatoid Arthritis
YES NO Other Arthritis Conditions
YES NO HIV/AIDS
YES NO Stroke
YES NO Anemia
YES NO Epilepsy
YES NO Heart Problems
YES NO Circulation Problems
YES NO Emphysema/Bronchitis
YES NO Thyroid Problems
YES NO Multiple Sclerosis
YES NO Depression
YES NO Hepatitis
YES NO Tuberculosis
YES NO Kidney Disease
YES NO Osteoporosis
YES NO Other __________

Has anyone in your immediate family (parents, brothers, sisters) EVER been treated for the following?
YES NO Diabetes
YES NO Tuberculosis
YES NO Heart Disease
YES NO High Blood Pressure
YES NO Stroke
YES NO Kidney Disease
YES NO Alcoholism (Chemical Dependency)
YES NO Cancer
YES NO Arthritis
YES NO Anemia
YES NO Headaches
YES NO Epilepsy
YES NO Mental Illness

Which of the following **OVER-THE-COUNTER** medications have you taken in the last week?

YES NO Tylenol
YES NO Advil/Motrin/Ibuprofen
YES NO Decongestants
YES NO Antacid
YES NO Other: ____________
YES NO Aspirin
YES NO Laxatives
YES NO Antihistamines
YES NO Vitamins/ Mineral Supplements

CURRENT MEDICATIONS (include non-prescription products)

Drug Dose Frequency

1. ________________________
2. ________________________
3. ________________________
4. ________________________
5. ________________________
6. ________________________

Please list any injuries, surgeries, or other conditions you have been treated or hospitalized for, including the approximate date, side, and reason for the treatment:

DATE: **REASON FOR INJURY/SURGERY/HOSPITALIZTION**
1.______ ________________________
2.______ ________________________
3.______ ________________________
4.______ ________________________

________________________ ________________________
Patient or Guardian Signature Date Therapist Signature Date

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ACKNOWLEDGMENT
NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that a copy of the WYOMING SPECIALIZED PHYSICAL THERAPY, INC. Notice of Privacy Practices is available to me. I further acknowledge and understand that if I have any questions about the WYOMING SPECAILIZED PHYSICAL THERAPY, INC. privacy practices or my rights regarding my personal health information, I may contact the appropriate person for further information as set forth in the Notice.

____ ________________

Name of Patient (and Patient's Representative, if one) Patient Account #

____ ________________

Signature of Patient (or Patient's Guardian) Date

<u>Staff Use Only:</u>

To Be Used by Office Staff Only If Patient Written Acknowledgement Is Not Obtained.

DOCUMENTATION SUPPORTING GOOD FAITH EFFORT TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: ______________________________ Patient Acct # ________________

I hereby certify that on ___/___/______ (MM/DD/YEAR), I made a good faith effort to obtain the above patient's written acknowledge of receipt of the Wyoming Specialized Physical Therapy, Inc. Notice of Privacy Practices, but I was unable to do for the following reason(s).

____

____

____

______________________________ ______________________________

Name of Staff Representative (Print) Signature of Staff Representative Date

No-Show/Cancelation Policy

Please Read Carefully

Thank you for choosing Wyoming Specialized Physical Therapy as your physical therapy provider.

We are sincerely dedicated in assisting you in meeting your therapy goals, we strive to provide each patient with the highest quality of care while attempting to accommodate your schedule at your convenience. In order to do this, it is important that you attend all scheduled therapy appointments. Consistent attendance allows you and your therapist to progress your treatment program which will result in a quicker recovery and better outcomes.

We realize that there are times when unforeseen circumstances make it impossible to attend your scheduled appointment. If this happens, please give us as much notice as possible so we can reschedule your appointment and open that time slot for another patient.

In order to enforce this policy, you will be responsible for a **$35.00** office charge if you cancel an appointment **less than 24 hour before or you do not show up for an appointment**. Your insurance does not cover charges for late cancelations or no-shows; it is the patient's responsibility.

We want to make your physical therapy experience as beneficial as possible and your commitment is a very important part of this.

I have read this policy and by signing below I am indicating that I understand and will adhere to this policy.

____

Signature of patient   Date

____

Signature of Responsible Party   Date

PATIENT PAYMENT AND INFORMATION AUTHORIZATION AGREEMENT

PLEASE READ CAREFULLY BEFORE SIGNING

1. I give my consent to be evaluated and treated at Wyoming Specialized Physical Therapy, Inc.
2. I understand that a copy of the **Notice of Privacy Practices** is available to me.
3. I understand that I am responsible for my statement each month.
4. I understand that **copays will be expected at the time of service.**
5. I agree to pay statement late fees, no show/cancelation fees, attorney fees and any additional fees if my account becomes delinquent and if it becomes necessary to turn my account over to a collection agency.
6. I understand it is my responsibility to provide WSPT with complete and accurate insurance information for WSPT to bill. The patient must also provide any other special requirements by the insurance company. The requirements may include but are not limited to, referrals from primary care physicians, accident information, or pre-authorizations from ordering doctors.
7. I understand that Wyoming Specialized Physical Therapy will bill my insurance company as a courtesy one time. We encourage you to follow up with your insurance company on all your claims to ensure timely processing and avoid any other delays.

REFERRAL (PRESCRIPTION):
A physician's referral for physical therapy treatment is required by some insurance companies for reimbursement. Physical Therapy services can be rendered without a referral, but cash payment will be required if your insurance carrier does not reimburse without a referral. Cash payment per visit is $125.00.

MEDICARE/WORKERS COMPENSATION PATIENTS:
Medicare and Worker's Compensation will not pay for a physical therapy visit unless the patient has seen their referring physician within 30 days of that visit. Please let us know when you see your doctor. If Medicare or Workers compensation does not pay for your physical therapy because you have not seen the doctor within 30 days of the physical therapy visit, the charges for services will be your responsibility. If workers compensation claims are not being paid due to objections then patient's private insurance will be billed, or the patient directly.

SECONDARY INSURANCE BILLING:
We will bill secondary insurance once the primary carrier has responded. If the primary insurance has made payment directly to the patient, we must have a copy of the Explanation of Benefits in order to bill the secondary carrier. In the event, the primary carrier has not responded to our claim, we will not take action to collect from the secondary carrier on the patient's behalf. **In the event that industrial or auto insurance exhausts or refused to pay I authorize Wyoming Specialized Physical Therapy, Inc. to bill my personal health insurance, or bill me directly**.

PAYMENT:
We allow 30 days for patients to pay their patient balance in full or set up monthly payment plan. All accounts not paid by 30 days will be assessed a late fee of 25% per month. Accounts not paid in full by 90 days will be assessed a 50% handling fee to the current balance and then turned over to a collection agency. The account balance is the responsibility of the patient or responsible party whether the insurance pays or not.

PAYMENT WITHOUT INSURANCE:
If the patient does not have insurance, payment for services rendered will be expected at the time of service.

PATIENTS NAME: ____ **DATE OF BIRTH**: ___________

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY: ___________________________ **DATE:**______

OFFICE REP: ____ **DATE**: ____________________

I guarantee payment of all physical therapy charges for treatment provided to the above-named patient to Wyoming Specialized Physical Therapy, Inc. I understand that I am financially responsible for all charges including but not limited to all co-payments, deductible, and expenses not covered or paid by insurance.