PATIENT INFORMATION

Name: (Last) _____ (First) _____ (MI) _____ (Jr., Sr., etc.) Sex: M or F

Street Address: _____ Apt./Space: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Age: _____ Social Security #: _____

Driver's License #: _____ State: _____ Marital Status: _____

Employer: _____ Occupation: _____ Employer Address: _____

CONTACT INFORMATION (Check the box next to the best contact number)

□Home phone: _____ □Work Phone: _____ □Cell Phone: _____

Email address: _____ (This is to receive appointment reminders via e-mail)

EMERGENCY CONTACT: _____ Relation: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

PARENT / RESPONSIBLE PARTY FOR PAYMENT: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____ Employer: _____

INSURANCE INFORMATION

Primary Ins: _____ **Insured Name:** _____ **DOB:** _____ **SS#:** _____

Secondary Ins: _____ **Insured Name:** _____ **DOB:** _____ **SS#:** _____

On the job injury? □YES □NO

Worker's Comp Insurance Co. _____ **Date of Injury:** _____ **Claim #:** _____

Auto Accident? □YES □NO Do you have an Attorney pertaining to this injury? □YES □ NO

If yes, Attorney's Name: _____ Attorney's Phone: _____

PREVIOUS THERAPY INFORMATION

Have you received any other Therapy Services this calendar year? □YES □NO

Have you received, or are you currently receiving Home Health Therapy? □YES □NO

If yes, please provide dates: _____ and the name of Home Health Agency: _____

Have you received, or are you currently receiving Chiropractic Treatment? □YES □NO

I hereby authorize payment of medical benefits to ANATOMIX PHYSICAL THERAPY Inc., for services furnished to me. I also hereby consent to have treatment and care as prescribed by my physician and / or recommended by the therapist. I also authorize the therapist to release any information in the course of my examination or treatment. This assignment will remain in effect until revoked by me in writing. A photocopy is to be considered as valid as the original. I HEREBY ACCEPT FINANCIAL RESPONSIBILITY FOR ALL CHARGES INCURRED WHETHER OR NOT I HAVE INSURANCE COVERAGE. VERIFICATION OF BENEFITS WE RECEIVE FROM YOUR INSURANCE COMPANY IS NOT A GUARANTEE OF PAYMENT.

_____ _____

Patient or Responsible Party Signature Date

PATIENT MEDICAL HISTORY

Name:_____ Primary Care Physician:_____

Referring Physician:_____ Date of Injury:_____ Follow up appointment:_____

Have you had surgery for this Injury: ____ Yes ____ No Date of Surgery: _____

□X-Rays Taken □MRI □CT Scan

Please list all medications you are currently taking. Please include dosage:

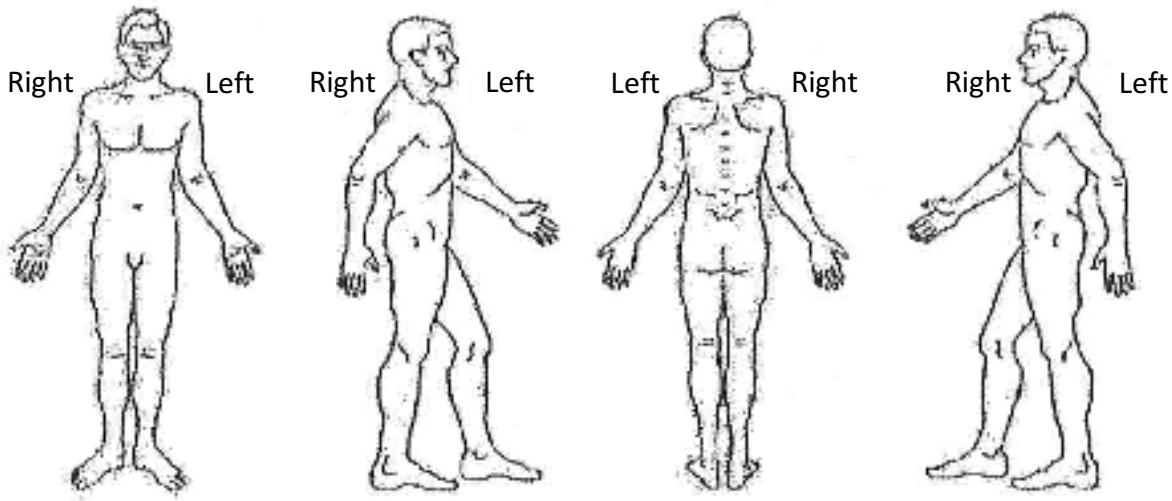
_____

_____

_____

PATIENT PAIN ASSESSMENT

Please indicate where your pain is located using the picture below



Please use the scale below to answer the following questions

NO PAIN AT ALL 0 1 2 3 4 5 6 7 8 9 10 WORST PAIN POSSIBLE

Please rate your current pain level:_____ Your pain at its worst:_____ Your pain at its best:_____

Please describe your pain (e.g. sharp, shooting, stabbing):_____

Please describe the frequency of your pain (e.g. constant, intermittent):_____

Please tell us what relieves your pain (e.g. rest, medication):_____

Please tell us what makes your pain worse (e.g. lifting, sitting, bending):_____

_____ _____ _____

Patient or Responsible Party Signature Therapist Signature Date

ANATOMIX FINANCIAL POLICY

TO OUR VALUED PATIENTS:
We are committed to providing you with the best possible care. If you have medical insurance, we are happy to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

We accept cash, checks, MasterCard, Visa, Discover, or American Express. We bill electronically, to expedite payment of claims. If you have an insurance that requires a paper claim to be completed, we will gladly mail this claim for you.

Please read carefully:

1. **PAYMENTS-** Copayments and payment for services are due at the beginning of **EACH** visit. If you have a deductible or coinsurance, we will estimate your responsibility to be paid on each visit and you will be billed or credited any balance as applicable once all claims have processed. **We are unable to waive patient responsibility, this includes copays, coinsurance, and deductibles.**

2. **IN NETWORK / OUT OF NETWORK**- **Your insurance is a contract between you, your employer, and/or your insurance company.** We are participating provider for most insurance companies. If we are in network, we will charge you no more than our contractual rate with your insurance company. If we are out of network with your insurance company and your claims are submitted to your insurance company, you will be responsible for all reasonable and customary charges as indicated on the explanation of benefits received from your insurance company. For more clarification on this, please speak with our Office Manager.

3. **BENEFIT LIMITS**- Some insurance plans have a financial or visit limit for physical therapy services. It is ultimately your responsibility to know your benefit limits. We have procedures in place to help you stay within any limits, but again it is ultimately your responsibility to keep track of your limits as if you exceed your limit, you will be responsible for charges not paid by your insurance company due to the exhaustion of your benefits.

4. **MEDICAL SUPPLIES / DME**- You will not be billed for any service not covered by your insurance company; however, we will not bill your insurance company for any medical supplies or DME (durable medical equipment) received. Payment for any supplies received, will be your responsibility prior to issuance of the supply.

5. **WORKERS COMPENSATION**- If your injury is work related, and a Workers Compensation claim has been initiated, you must provide our office with your claim number, adjuster's name and phone number before your initial visit. Please be advised that if your account is not paid by you comp. carrier, you will be responsible for all charges within 30 days of notification.

Our Relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are 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. Should your account become delinquent, we will no longer continue to schedule additional visits until balance are paid in full.

I _____ **have read and understand the above policies on** _____**.**
Patient or Responsible Party Signature Date

ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Anatomix Physical Therapy, Inc. / Anatomix Physical Therapy – Mandeville LLC Notice of Privacy Practices. By signing below I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

_____	_____
Patient Name (Type or Print)	Patient's Date of Birth
_____	_____
Signature of Patient or Parent/Legal Guardian	Date