

**PHYSICIANS' CHOICE PHYSICAL THERAPY, INC.**

**2346 South Range Avenue ♦ Denham Springs , LA 70726 ♦ 225-665-8080 (P) 225-665-0999 (F)**

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**PATIENT RECORD**

**PATIENT INFORMATION**

**Patient Name:** \_\_\_\_\_ **Marital Status:** M / S / O

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_

**State** \_\_\_\_\_ **Zip** \_\_\_\_\_ **Home#:** \_\_\_\_\_ **Work#:** \_\_\_\_\_

**SSN:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **Sex:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Patient Seen Here Before:** Yes / No **Circle One:** No Accident / Auto Accident / Other Accident

**REFERRAL INFORMATION**

**Referring Doctor:** \_\_\_\_\_ **Reason For Referral:** PT / OT / ST

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_

**State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_ **Phone#:** \_\_\_\_\_ **Fax#:** \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_ **RX Date:** \_\_\_\_\_ **Date Of Injury:** \_\_\_\_\_

**How did you hear about Physicians' Choice Physical Therapy?**

- Newspaper-Name of Newspaper \_\_\_\_\_  TV ad  Mail-out  
 Friend/ Relative-Name of friend/relative \_\_\_\_\_  
 Doctor Referral-Name of Doctor \_\_\_\_\_  Saw sign while passing by  
 Other \_\_\_\_\_

**RESPONSIBLE PARTY**

**Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Relation to Patient:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_

**State** \_\_\_\_\_ **Zip** \_\_\_\_\_ **Work#:** \_\_\_\_\_ **Fax#:** \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**EMPLOYER INFORMATION**

**Place of Employment:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_

**State** \_\_\_\_\_ **Zip** \_\_\_\_\_ **Work#:** \_\_\_\_\_ **Fax#:** \_\_\_\_\_

**Employment:** Full Time / Part Time / Unemployed / Retired **Student:** Full Time / Part Time

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**PRIMARY INSURANCE / ATTORNEY INFORMATION:**

**Primary:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_

**State** \_\_\_\_\_ **Zip** \_\_\_\_\_ **Phone#:** \_\_\_\_\_ **Group#:** \_\_\_\_\_ **ID#:** \_\_\_\_\_

**Auth. Required: Yes / No** **Auth. #:** \_\_\_\_\_ **Contact:** \_\_\_\_\_

**Eff. Date Of Policy:** \_\_\_\_\_ **Type Of Therapy:** PT / OT / ST **OOP:** \_\_\_\_\_

**Co-Pay Flat: \$** \_\_\_\_\_ **%** \_\_\_\_\_ **Deductible: \$** \_\_\_\_\_ **Yearly Max: \$** \_\_\_\_\_

**SECONDARY INSURANCE / ATTORNEY INFORMATION:**

**Secondary/Attorney:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_

**State** \_\_\_\_\_ **Zip** \_\_\_\_\_ **Phone#:** \_\_\_\_\_ **Group#:** \_\_\_\_\_ **ID#:** \_\_\_\_\_

**Auth. Required: Yes / No** **Auth. #:** \_\_\_\_\_ **Contact:** \_\_\_\_\_

**Eff. Date Of Policy:** \_\_\_\_\_ **Type Of Therapy:** PT / OT / ST

**OOP:** \_\_\_\_\_

**Co-Pay Flat: \$** \_\_\_\_\_ **%** \_\_\_\_\_ **Deductible: \$** \_\_\_\_\_ **Yearly Max: \$** \_\_\_\_\_

**\*\*\*NOTICE\*\*\***

**Appointment cancellation is required ahead of time. Please leave a message if you are calling past business hours. Failure to give this notice will result in a \$15.00 no-show charge,**

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**My insurance plan of benefits and eligibility has been explained and I fully understand and agree to my responsibility regarding the benefits of my insurance.**

**We will need a copy of your insurance card, driver's license, and prescription from your doctor for Physical, Occupational, or Speech Therapy. Please inform us of any change in insurance coverage, as most insurance companies require pre-authorization for therapy. Without pre-authorization this could leave you responsible for the bill without insurance reimbursement.**

**By signing, you agree that the information on the Patient Record is complete and true to the best of your knowledge. You also agree to inform us of any changes you may have such as address, phone #, insurance, etc. Thank you for choosing Physicians' Choice Physical Therapy, Inc. for your healthcare needs.**

\_\_\_\_\_  
**Authorized Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Witness**

\_\_\_\_\_  
**Date**

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**PATIENT HISTORY**

**Please indicate any of the following that apply to you:**

CONDITION	YES	NO	EXPLAIN
Diabetes, emphysema, birth defects, chest pains, heart condition or heart murmur.			
Rheumatic fever, blood abnormality, disease or disorder, seizures, epilepsy, stroke or circulatory or vascular abnormality?			
Disease or disorder including high blood pressure, heart disease, varicose veins, and phlebitis?			
Bronchitis, asthma or other respiratory abnormality, disease or disorder, including allergies?			
Any abnormality disease or disorder of the thyroid, intestines, liver, gall bladder, kidney or stomach, including ulcers, prostate, reproductive organs?			
Gout, arthritis or other abnormality, disease or disorder of the muscles, bones, tendons or joints including the back of the spine, or broken bones?			
Mental, emotional or nervous abnormality disease or disorder of the muscles, bones, tendons or joints including the back of the spine, or broken bones?			
Cancer or tumors (benign or malignant), lymph node abnormality, disease or disorder, history of sexually transmitted diseases?			
Any abnormality, disease or disorder of the male or female reproductive system, including all gynecological abnormalities, disease or disorders, infertility and male genital abnormalities, disease or disorders?			
Pacemaker or Metal Implants?			
Are you pregnant?			
Any previous surgeries?			
Are you currently taking any medications?			

**By signing, you agree that the information on the Patient History is complete and true to the best of your knowledge.**

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Therapist Signature

\_\_\_\_\_  
Date

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**TREATMENT AGREEMENT**

**Thank you for choosing us as your healthcare provider. We hope to be of valuable service to you. Before we get started, there are a few guidelines that we must follow and you must understand.**

1. We are required to have a written physician's prescription for Physical, Occupational or Speech Therapy before you receive treatment. If verbal phone orders are received, this will suffice, but written orders must follow.
2. **For you first scheduled appointment**, we request that you arrive at least 30 minutes prior to your scheduled appointment time so that treatments need not be altered or modified.
3. We require you to call in advance of any appointment cancellation. Your insurance company will not tolerate multiple appointment cancellations and no show appointments. Consistent cancellations or no show appointments will require discharge from this clinic and notification to your referring physician.
4. Prior arrangements must be made for the proper payment method you choose. We accept all possible methods of payments that include: Cash Accounts, Worker's Compensation, Private Insurances, Auto Liability Insurances, and Attorney Accounts.
5. Notify this office immediately if you hire an attorney at any time during or after your services. This will allow us to make proper adjustments for billing purposes.
6. Your bill is your financial responsibility not your insurance company, nor your attorney. The billing department will make every effort to file your insurance.
7. We accept cash, checks and several credit cards for any uncovered services, co-payments or deductibles that are due at the time services are rendered. If your insurance does not pay in full within 45 days, we require you to pay the balance due by the above named methods or set up an installment plan.
8. Returned checks are subject to a \$30.00 service fee. Outstanding balances greater than 90 days are subject to interest charges of 1.5% per month

**AUTHORIZATION AND RELEASE**

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such are to the third party payers, your employer, Vocational Rehab., Counselor, Worker's Compensation Carrier, Third Party Administrator , Employee Case Manager, Safety Officer/Manager and/or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of my dependants.

**CONSENT TO TREAT**

I agree to treatment by a registered therapist as prescribed by a physician.

\_\_\_\_\_  
**Authorized Signature**

\_\_\_\_\_  
**Date**

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**NOTICE OF PATIENT INFORMATION PRACTICES**

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**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION, PLEASE REVIEW IT CAREFULLY.**

**(PCPT)**

PCPT is required by law to protect the privacy of our personal health information, provide this notice about our information practices and follow the information practices that are described herein.

**USES AND DISCLOSURES OF HEALTH INFORMATION**

PCPT uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, PCPT may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

PCPT may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, PCPT policy is to obtain your written authorization before disclosing your health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosure at any time.

PCPT may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

**PATIENT'S INDIVIDUAL RIGHTS**

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. PCPT will consider all such request on a case-by-case basis, but the practice is not legally required to accept them.

**CONCERNS AND COMPLAINTS**

If you are concerned that PCPT may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on PCPT health information practices or if you have a complaint, please contact the following person:

**PHYSICIANS' CHOICE PHYSICAL THERAPY, INC.  
PAULETTE MOHAMED  
2346 South Range Avenue  
Denham Springs, LA 70726**

**PHYSICIANS' CHOICE PHYSICAL THERAPY, INC.**  
**PATIENT INFORMATION CONSENT FORM**

I have read and fully understand PCPT Notice of Information Practices, I understand that PCPT may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that PT/OT will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in PCPT Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

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**PATIENT NAME**

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**SIGNATURE**

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**DATE**

