GRANDVIEW
PHYSICAL THERAPY

For official use only:
Physical Therapist:_____
Diagnosis Code:_____

Patient's Name:_____ Home Phone:_____

Address:_____ Cell Phone #:_____

City:_____ State:_____ Zip Code:_____

Date of Birth:_____ Sex: ☐ Male ☐ Female S.S. #:_____

Employer:_____ Work Phone:_____

Employer address:_____ City:_____ State: _____ Zip Code:_____

Referring Physician:_____ Physician's address:_____

City:_____ State:_____ Zip Code:_____ Phone #:_____

***If Married*: Spouse's Name:_____ Employer:_____**

Home Phone:_____ Work Phone:_____ DOB:_____

PLEASE COMPLETE IF PATIENT IS A MINOR:

Mother/Guardian's name:_____ Address:_____

City:_____ State:_____ Zip Code:_____ DOB: _____

Employer:_____ Address:_____

City:_____ State:_____ Zip Code:_____ Phone #:_____

Father/Guardian's name:_____ Address:_____

City:_____ State:_____ Zip Code:_____ DOB:_____

Employer:_____ Address:_____

City:_____ State:_____ Zip Code:_____ Phone #:_____

***INSURANCE INFORMATION*: Please present the front office with insurance cards**

Primary Insurance Carrier's Name:_____ Address:_____

Subscriber's Name:_____ Employer Name:_____

Subscriber's ID #:_____ Group #:_____ Date of Birth:_____

Secondary Insurance Carrier's Name:_____ Address:_____

Subscriber's Name:_____ Employer Name:_____

Subscriber's ID #:_____ Group #:_____ Date of Birth:_____

Is treatment a result of a: ☐ On the job injury ☐ Auto ☐ Accidental

Date of Injury:_____ Claim #:_____

Emergency Contact: Name:_____ Phone:_____

I authorize Grandview Physical Therapy to use and disclose health and medical information for the purposes of treatment, payment and health care operation: . Under all circumstances I assume final responsibility for my account understanding that in the event my account becomes delinquent, I agree to pay accrued finance charges, court costs and attorney fees. I consent to physical therapy services prescribed by any physician. I authorize payment of medical benefits by my insurance company to Grandview Physical Therapy for services rendered. I have received this practice's Notice of Privacy Practices written in plain language.

Signature:_____ **Date:**_____

Authorization for Release of Information: I authorize the release of medical information to the person(s) named below:

☐ **All Medical and Billing Information** ☐ **Appointment Information Only**

_____ _____ _____

Name, Relationship to Patient & Date **Name, Relationship to Patient & Date** **Name, Relationship to Patient & Date**

Patient History

GRANDVIEW PHYSICAL THERAPY Grandview Physical Therapy, P.S.

Name _____ Date _____

1. What is your problem or injury? _____

2. How did your problem or injury begin? _____

3. How long ago did it begin? _____

4. What is your type of work? _____

5. Are you working? . . . . . ❑ Yes ❑ No
   If no, is it because of your problem? . . . . . ❑ Yes ❑ No

6. Before this injury were you completely free of symptoms? . . . . . ❑ Yes ❑ No

7. Have you ever had anything similar before? . . . . . ❑ Yes ❑ No

8. What, if any, treatments have you had for this current problem?
   Check one: ❑ Physical therapy ❑ Chiropractic ❑ Medical ❑ Other

9. What eases your pain? . . . . . ❑ Sitting ❑ Standing ❑ Walking ❑ Lying down

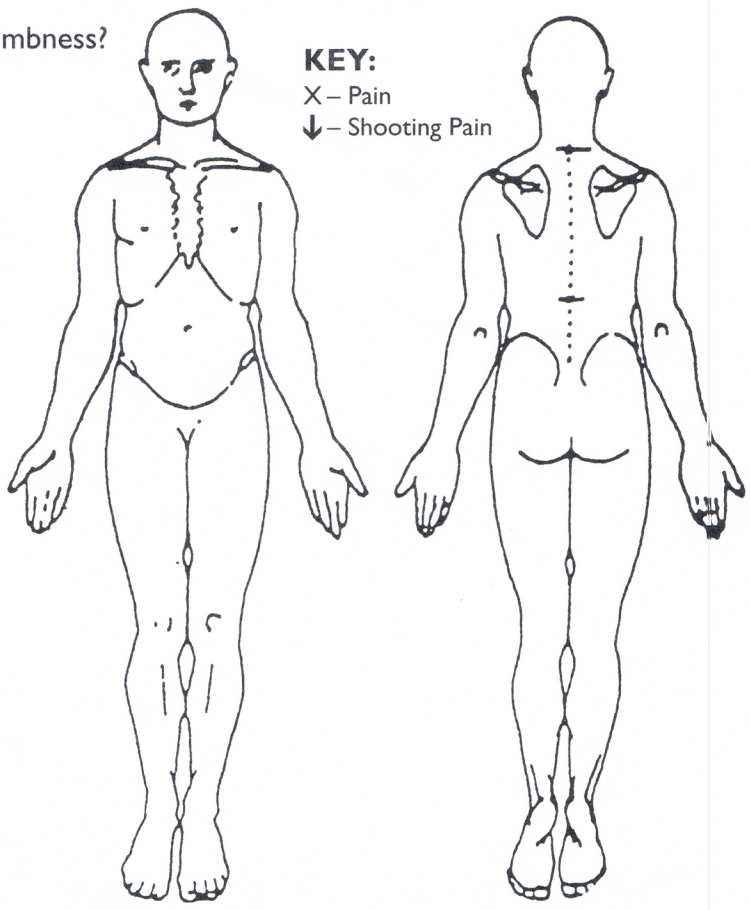
10. What makes your pain worse? . . . . ❑ Sitting ❑ Standing ❑ Walking ❑ Lying down

11. Do you have any feelings of pins and needles or numbness?
    ❑ Yes ❑ No

12. Do you have any other problems?
    ❑ Yes ❑ No

13. Are you taking any medications?
    ❑ Yes ❑ No
    What kind? _____

KEY:
X – Pain
↓ – Shooting Pain



14. Show on the body figure the places of discomfort.

NEW PATIENT INSURANCE INFORMATION FORM:

Revised 3/3/04

Patient's name:_____

(1) Insurance Company:_____

Insurance Phone #:_____

(2) Insurance Company:_____

Insurance Phone #:_____

INSURED INFORMATION:

1St Insurance:

Name:_____

Date of birth:_____

Social Security #:_____

Policy or Claim #:_____

DOI/DOA: _____

Dx Code: _____

2nd Insurance:

Name:_____

Date of birth:_____

Social Security #:_____

Policy or Claim #:_____

DOI/DOA: _____

Dx Code: _____

CHECKLIST FOR CALLING INSURANCE COMPANIES:

	(1st Insurance)	(2nd Insurance)
Name of person calling insurance:	_____	_____
1. Effective date of patients policy:	_____	_____
2. Did they have max?	_____	_____
Dollar amount for PT or max. # of visits?	_____	_____
3. What percentage does insurance pay?	_____	_____
4. What is patient portion (i.e. % or co-pays)?	_____	_____
5. Has deductible been met?	_____	_____
6. Do they need pre authorization?	_____	_____
7. Do they need doctor prescription?	_____	_____
8. Name of person speaking to:	_____	_____
Date:	_____	_____

DSHS Patients: Ask the patient if they have received physical therapy from any other physical therapy clinic so far this year: Yes____ No____

If yes, how many visits have they had: _____

DSHS patients are limited to 12 treatments per year unless they have a special diagnosis.

Is the patient straight DSHS: Yes____ No____ if no, phone call is required.

Is the DSHS patient PBC, Regence or CHIS/CHPW: Yes____ No____ if so, pre-authorization and a phone call are required.

We are contract to see Molina patients

If DSHS card states CNP they have physical therapy coverage. Any other initials phone call is required.

Medicare Patients: Does the patient have a Medicare card: Yes____ No____

If no, a phone call to Medicare to verify coverage is required.

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