

Welcome to Mary Lou Corcoran Physical & Aquatic Therapy

Patient Information Form – *Please complete entire form.*

Personal Information

Patient's Name: _____ Date: ____/____/20____
First MI Last

SS #: _____ - _____ - _____ Date of Birth: ____/____/____ Male
 Female

Home Phone #: _____ Cell Phone #: _____

Emergency Contact: _____ Phone #: _____

Referring Doctor: _____ Primary Care Doctor: _____

How did you hear about Mary Lou Corcoran Physical Therapy?: _____

Insurance Information

Type of Insurance: Private Insurance Workers Compensation No Fault

Please list *all* insurances. If you are being treated for a Workers Compensation case or a No Fault claim please list the case/claim under Primary Insurance and your private insurance under Secondary Insurance Information.

Primary Insurance Carrier: _____

Policy Holder: _____ DOB: _____ SS# _____

Insured's Employer: _____

Secondary Insurance Carrier: _____

Policy Holder: _____ DOB: _____ SS# _____

Insured's Employer: _____

MEDICARE PATIENTS

➤ Have you received any physical therapy or speech therapy this year? YES NO

If yes, where: _____ When: _____

➤ Have you had Home Health Care in the past 90 days? YES NO

If yes, which agency? _____ Date of Discharge: _____

Reason for Referral/Diagnosis: _____

Are you taking any medications now? YES NO If yes please list all medications below or attach list::

MEDICATION	REASON FOR TAKING MEDICATION

Do you have now, or have you ever had, any of the following conditions? Please check all that apply.

CONDITION	YES	NO	CONDITION	YES	NO
Are you pregnant NOW?			Allergy to tape/latex		
Electronic Implant			Bladder/bowel problems		
Pacemaker			Osteoporosis		
Rheumatoid Arthritis			Osteoarthritis		
High blood pressure			Heart problems		
Cancer			Seizures		
Diabetes			Asthma		
Alcoholism					

I authorize Mary Lou Corcoran Physical & Aquatic Therapy to discuss my medical information with the following (indicate all that apply):

Spouse: _____ Phone #: _____

Family Member: _____ Phone #: _____

Doctor: _____ Phone #: _____

Attorney: _____ Phone #: _____

Case/Claim Manager: _____ Phone #: _____

Other: _____ Relationship: _____ Phone #: _____

Other: _____ Relationship: _____ Phone #: _____

I hereby assign all medical benefits, to which I am entitled, including Medicare, private insurance, major medical and any other plan to Mary Lou Corcoran Physical & Aquatic Therapy, PC (MLCPT). I understand I am responsible for providing all of my insurance information. Medicare beneficiaries are responsible for charges in excess of the **\$1860.00 physical therapy cap**. This assignment will remain in effect until revoked by me in writing . A photocopy of this assignment is to be considered as valid as **an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I understand copay/coinsurance is due at the time of service and additional balances will be billed to me.** I understand it is possible that my fee for service may be different then the copay/coinsurance amount provided to me as a courtesy by MLCPT. I also agree to pay any and all attorney's and/or collection fees of a reasonable amount on the unpaid balance, if this account is referred to collection. I certify that the information given by me in applying for payment under title XVIII of Social Security Act is correct. I hereby authorize said assignee to use or disclose all information necessary for treatment, obtaining payment and health care operations. I hereby authorize Mary Lou Corcoran, P.T. to perform any medical treatment as deemed necessary. **I understand that as a patient I am responsible for maintaining a valid prescription and will contact my doctor's office to obtain an updated one when necessary.** I have been notified that the HIPPA policy is posted in the waiting area and a copy of this policy is available to me upon request. I have read and agree to the Office Policies.

Signature of patient or parent/guardian if minor

Date

Mary Lou Corcoran Physical & Aquatic Therapy

OFFICE POLICIES

- Upon arrival please sign-in at the front desk for each appointment.
- Copay/Coinsurance is due at the time of each appointment.
- Our HIPPA policy is posted in the waiting area, a copy of this policy is available upon request.
- Arrive 5 minutes early for each appointment to schedule your follow-up appointments and to pay copay/coinsurance.
- Notify the office 24 hours in advance if you are unable to attend an appointment.
- Patients are responsible for scheduling each appointment. We recommend scheduling appointments 1 week in advance.
- If a patient misses 3 appointments they may be discharged.
- Insurance companies require patients to have a prescription from their referring doctor to attend physical therapy. Prescriptions expire 30 days from the date the prescription was written (unless otherwise specified ie: 3 weeks or 6 weeks). Patients are responsible for contacting their Doctor to renew an expired/expiring prescription.
- Notify the front desk immediately of any changes in insurance, address or phone numbers.
- Patients are responsible for knowing their insurance benefits including, but not limited to copay/coinsurance, deductible, referrals, and visit limits.

