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 a 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

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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

WORKERS COMPENSATION INFORMATION

Patient Name: ____ **Acct #:** ____________________________

Diagnosis/Injury: ____ Date of Injury: _______________________

Name of Employer at the time of injury: ____

Employer Address: ____

Employer Phone Number: ____

Compensation Carrier: ____ Claim Number:_______________________

Carrier Address: ____

Adjusters Name: ____ Carrier Phone #: _____________________

Are you currently receiving chiropractic care? YES NO

I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT IN THE EVENT THAT MY CLAIM IS DENIED. I MUST PROVIDE MY PRIVATE INSURANCE TO BE KEPT ON FILE IN THE EVENT OF A DENIAL.

Additional Notes: ____

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PLEASE READ AND KEEP THE FOLLOWING OFFICE POLICIES TO ENSURE YOU HAVE THE BEST PHYSICAL THERAPY EXPERIENCE.

Appointments:

- Appointments are available Monday – Friday from 6:30am until 6:00 pm. The front desk is available from 6:15am thru 5:45pm.
- To ensure you receive appointments that best fit into your schedule, please book them at least 48 hours in advance.
- Appointments are not automatically schedule and must be booked by the patient.
- Arrive 5 minutes early for each appointment, upon arrival:
    - Sign-in at the front desk
    - Make copay/coinsurance payment
- Notify the office 24 hours in advance if you are unable to attend an appointment. A patient who misses 3 appointments may be discharged.

Prescriptions:

- Prescriptions expire one month from the date they were written.
- Patients are responsible for maintaining a valid prescription and should request an updated prescription form their Doctor every 30 days.

Reevaluations:

- Reevaluations are required by both insurance companies and Doctors every thirty days for all patients.

Copays/Insurance Benefits:

- All copays and coinsurances are due at the time of each appointment.
- Patients are responsible for knowing their insurance benefits including but not limited to copay/coinsurance, deductible, referrals & visit limits.
- Any balance not paid at the time of service will be billed, any balances unpaid after thirty days are subject to a finance charge.
- The patient is responsible for notifying the front desk of any changes in insurance, address or phone numbers.

HIPPA: • Our HIPPA policy is posted in the waiting area, a copy of this policy is available upon request.

If you have any questions, concerns or feedback regarding your experience at Mary Lou Corcoran Physical & Aquatic Therapy please contact Sarah Howarth, Director of Business Operations, 637-4747 ext 317 or email showarth@cnymail.com

Have you had physical, occupational, or speech therapy at any other location than MLCPT this year? ❑ YES ❑ NO

If YES, how many? ________________________

I understand I am responsible for knowing my insurance benefits; the above benefit information is provided as a courtesy and is based on the information quoted by the insurance representative to MLCPT. Should my actual benefits differ from the above I am responsible for any difference. I understand all copays, coinsurances, & deductibles are due at the time of service.

____ _______________________________

Responsible Party Signature Date