DURANT PHYSICAL THERAPY, LLC

PATIENT DEMOGRAPHIC FORM

Patient name: _____Sex: M or F Date of Birth: ____/____/____ Age: _____

Address: _____City: _____State: ____ Zip: _____

Home phone: _____Cell phone: _____

Email Address_____

I authorize Durant Physical Therapy to contact and/or leave a personal message on the following phone numbers and/or email address: **Initial all that apply** (H) _____(C) _____ (W)_____ (Email) _____

Emergency Contact: _____Relationship: _____ Phone: _____

How did you hear about us: _____

Insurance Information:

Primary Insurance**:** _____ ID#: _____

Secondary Insurance: _____ ID#: _____

Referring Doctor:

Print Name: _____ Phone: _____ Fax: _____

Primary Care Physician: ***Required for Direct Access Patients***

Print Name: _____ Phone: _____ Fax: _____

Employer:

Company: _____Occupation:_____Phone:____ _____

Address: _____ City: _____State: ____Zip: _____

Legal Information (Used only for MVA or W/C Injury)

Attorney: _____ Phone: _____

Address: _____State:_____ Zip: _____

Patient Agreement:

I, the undersigned, have insurance coverage with_____
and assign directly to Tim Durant Physical Therapy all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I also acknowledge receipt of this office's H.I.P.P.A. notice of privacy policies.

*****We understand that life happens. The cancellation/no show fee will be waived for your first late cancel or no show visit, all cancel/no shows thereafter will be charged a $50 cancellation fee to you, not your insurance company.*****

Signature: _____ Date: _____

Durant Physical Therapy, LLC

Medical History Form

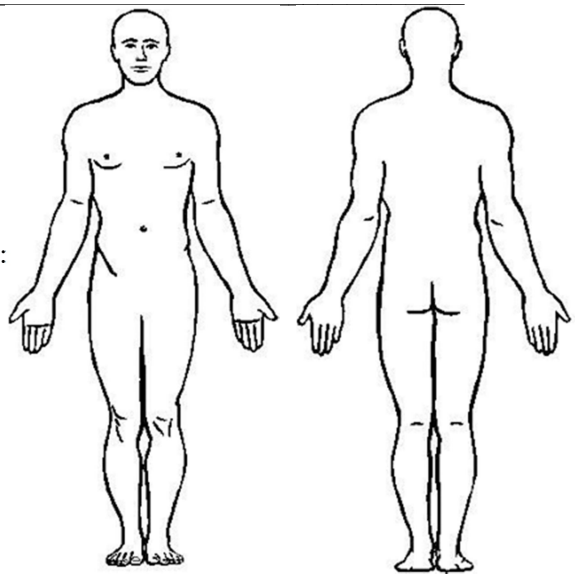
Name:_____ Date of Birth___/___/___ Date of Injury___/___/___
Current Medications:_____
Allergies:_____
Primary Care Physician: _____ Are you pregnant: Yes___ No___
Please list any tests and results (x-ray, MRI, etc) _____
_____

Do you have any past or present history of:	**YES**	**NO**
Heart Disease, High Blood Pressure, Angina, Pacemaker?	_____	_____
Respiratory Problems, Asthma, Allergies, TB?	_____	_____
Diabetes (ANY TYPE)?	_____	_____
Arthritis diagnosed by M.D.?	_____	_____
Bone Disease?	_____	_____
Skin Disorders, Eczema, Psoriasis, Athlete's Foot?	_____	_____
Communicable Disease, Hepatitis, TB?	_____	_____
History of Cancer (ANY TYPE)?	_____	_____
Any metal or artificial implants?	_____	_____
Any previous motor vehicle accidents with injuries?	_____	_____
Any previous surgeries?	_____	_____
Any history of seizures or epilepsy?	_____	_____
Do you have any latex allergies?	_____	_____

If you answered YES to any of the above questions, please explain and give the date of occurrence(s):
_____
_____

In the diagram on the right, please mark the area(s) where your pain is located using the following symbols:

X: PAIN
///: PINS AND NEEDLES
O: NUMBNESS
***: SHOOTING PAIN**



Please rate your pain right now on a scale of 0-10 with 0 being no pain at all and 10 being the worst pain imaginable:

The pain at its lowest? ____/10
The pain at its highest?____/10

Please describe your pain (circle all that apply)
Constant Intermittent Sharp Dull Aching Burning

Tingling Stabbing Throbbing Shooting Cramping

Signature: _____ Date: ___/___/___

Durant Physical Therapy, LLC

ASSIGNMENT OF BENEFITS

I hereby assign benefits to include major medical benefits, private insurance and any other plan to Durant Physical Therapy. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges not covered or not paid by said insurance at the time of service. I hereby authorize said assignee to release all information necessary for payment purposes.

Note: Any estimates of benefits disclosed to us by the insurance representative are merely estimated coverage information we obtain, and are in no way intended to release the patient from total responsibility for their account or be implied as guarantee of payment by the insurance carrier. The patient will be financially responsible for all charges not covered by said insurance. ***It is a policy of our office not to exceed a balance of $150 throughout treatment. This includes, but not limited to: copays, deductibles, co-insurances and self-pay patients.*** **(**Please Initial) _____

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

If I am covered by an insurance plan that requires a referral and I do not obtain one from my Primary Care Physician or specialist, I will be responsible if my insurance carrier does not pay the claim. This statement also applies to future visits if the referral has expired or additional visits need to be authorized. I am responsible to keep track of my referral. I will be sure to keep a copy of the referral or call my insurance carrier and confirm that a referral was received from my Primary Care Physician or specialist. If I am being treated for a work-related injury, I am required to comply with the referral policy of my employer's insurance plan.

ATTENDANCE

I understand that good attendance is essential to receive the most benefit from my therapy program. I will inform Durant Physical Therapy if I am unable to keep my appointment and give 24 hours notice if possible. I understand that Durant Physical Therapy will make every effort to reschedule my appointment. If I am late for an appointment I understand that the therapist will see me as the schedule permits. I understand that failure to keep my appointments may result in the therapist discussing this with my doctor and may result in discharge.

CONSENT FOR TREATMENT

I hereby give Durant Physical Therapy my consent for any necessary medical evaluation and treatment.

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I have read and understand all the above policies and I agree to them. I understand, per my insurance contract, that I am financially responsible for any and all charges not paid by my insurance carrier.

_____ _____

Patient / Legal Representative Signature Date

If signed by a legal representative, indicate your relationship to the patient:

( ) Parent ( ) Guardian ( ) Conservator* ( ) Executor of estate* ( ) Power of attorney*

_____ _____

Witness to signature (if legal representative signs) Date

Cancellation / No-Show / Late Walk-In Policy

Durant Physical Therapy Staff understands that unplanned issues can occur and that patients need to cancel or reschedule an appointment. As an office we do our best to accommodate for unforeseen circumstances resulting in late arrivals to the office; this is not always possible. Please keep in mind when a patient does not attend a scheduled appointment, another patient loses an opportunity to be seen.

To allow our therapists to have adequate time with their patients our policies are as follows:

- If a patient is more than 15 minutes late for an appointment, Durant Physical Therapy reserves the right to cancel the appointment and charge a $50 late cancellation fee.
- A scheduled appointment **MUST BE CANCELLED AT LEAST 24 HOURS IN ADVANCE, OR THE PATIENT WILL BE CHARGED A $50 LATE CANCELLATION FEE.**
- A late cancellation may be rescheduled to **AVOID THE CANCELLATION FEE** if the appointment is rescheduled within the same Monday - Friday period (prior to the upcoming weekend). In other words, if a patient begins the week with two appointments and completes the week having had two treatments, no cancellation charges will be assessed if one appointment had been late cancelled and rescheduled.
- If a patient does not honor a rescheduled appointment, **THE PATIENT WILL BE CHARGED FOR BOTH THE ORIGINAL CANCELLATION AND THE RESCHEDULED APPOINTMENT.**
- Should a patient miss two consecutive appointments without calling to cancel, the patient will be taken off the master schedule and will forfeit all further permanent appointments.
- **PLEASE INFORM THE FRONT DESK STAFF OF ALL SCHEDULING CHANGES. YOUR THERAPIST IS RESPONSIBLE FOR YOU THERAPY AND CAN NOT BE RESPONSIBLE FOR YOU SCHEDULE.**

Patient Signature _____ Date_____

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Thank you for being a valued patient and for your understanding and cooperation as with this policy. Please help our Physical Therapists be available for your needs and the needs of all our patients.

The Staff at Durant Physical Therapy

DURANT PHYSICAL THERAPY, LLC
2928 MAIN STREET 2ND FLOOR
GLASTONBURY, CT 06033
(860)430-2344

HIPAA Release Form

I have read the "NOTICE OF PRIVACY POLICIES for DURANT PHYSICAL THERAPY, LLC and understand that all the information regarding:

1. Patient Authorization regarding the privacy notice.
2. Patient Authorization for appointments and scheduling matters.
3. Patient Authorization regarding physical therapy related health services.

Patient Signature: _____ Date: _____

I give authorization for my health information to be shared with the following individual(s), physician(s) or organization(s)

Name:_____ Relationship:_____

Organization:_____

If you are a minor or if you are being represented by another party:

Representative Signature: _____ Date: _____

Description of the authority to act on behalf of the above patient

This authorization may be revoked by you at any time. Revocation may be accomplished by advising Durant Physical Therapy in writing you desire to withdraw you authorization. Processing time will be completed within a reasonable amount of time.