Partners in Physical Therapy
3221 Ryan Street Suite D. Lake Charles, LA 70601
337-439-3344 phone 337-439-3380 fax
www.partnersinpt.com

Dear Patient,

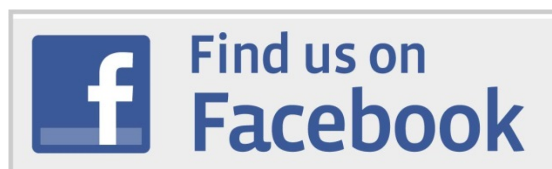
We know you have a choice in physical therapy clinics and we would like to thank you for choosing our office. We take your care and participation in therapy seriously. It is our mission to provide you with excellent care and work as a team with you and your healthcare provider to ensure that your goals are met.

As a part of our efforts to offer excellence in patient care, we are proud to announce the incorporation of a patient advocate to our treatment staff. Erin MacInnes, LCSW is a clinical social worker is available as needed. She can help to assess your progress towards your goals as well as any barriers. She will relay that information to your therapist so that we can modify or update your treatment program to help you achieve your goals faster and she can help with creating action plans to decrease barriers. Please feel free to request a session with Erin.

If you have any questions, please feel free to contact me at 337-439-3344, ext. 0

Again, welcome to our clinic. You are now officially a partner!

Freddie Ann Regan Chandler,
Owner and Physical Therapist



P.S. We recommend that you follow our Partners in Physical Therapy Facebook Page.

It helps you get to know us!
It helps keep you informed of clinic closures or changes!
It gives you useful resources that may help your condition!

Partners in Physical Therapy New Patient Packet

How did you hear about us? (Please circle) **Physician** **Friend** **Previous Patient** **Website** **Other:** ______________________________

Name: ____ **Date of Birth:** _____________________

Address: ____

City: _____________________________________ **State:** __________ **Zip:** ____________________

Email: ____________________________________ **Home Phone:** _______________________________

Work Phone: _______________________________ **Cell Phone:** _______________________________

Social Security #: __________________________ **Sex: M F** **Marital Status: S M D W**

Employer: ____

Circle: **Auto Accident** **Worker's Comp** **Date of accident:** _____________________

Name of attorney or case manager: _________________________________ **Phone:** _____________

Insured Name

(Same as above? YES NO)

Name: ____ **Date of Birth:** _________________

Address: ____ **Social:** ________________________

City: ____ **State:** ___________ **Zip:** _____________

Emergency Contact

Name: ____ **Relationship:** ___________________

Home Phone: __________________________ **Other:** ________________________________

Are we authorized to release information to this individual? YES NO

Please list any other individuals that we may share health or personal information:

____

____

Patient/Guardian: _______________________________________ **Date:** ____________________

(Signature)

PLEASE TAKE THE TIME TO READ EACH PAGE

Partners in Physical Therapy Policies

We work hard so that our office consistently runs on time and your physical therapy goals are met.

Please be aware of the following:

Be here on time: We start and end appointments on a set schedule. It is important that you arrive on time.

Courtesy Reminder: We send SMS notifications at 12 noon the day before your appointment.

Appointment Changes: A minimum 24 hour notice for changes in appointment time is required. Cancelation with less than 24 hour notice will be charged $50.00.

No Shows: If you do not show up for an appointment, a $50.00 no show charge is due at your next visit. This charge is your responsibility and will not be billed to insurance or other payers.

25% Cancellation/No Show Policy: If you miss greater than 25% of your scheduled appointments we reserve the right to cancel all future appointments. *Example: 3 out of 12 missed*

Workman's Compensation: We are required to send documentation of missed appointments to your worker's compensation case manager.

Self-Discharge: Please do not stop therapy without talking to your therapist.

Supplies: We do not bill insurance for medical supplies. Therefore, payment is due at the time of service. If you would like to bill your insurance for supplies, please talk with our billing department for assistance.

Insurance benefits: Please be aware that our office works extremely hard to get your benefits and claims processed correctly. However, it is not possible for our office to guarantee insurance participation or benefits due to the significant number of individual policies that exist. Therefore, we **STRONGLY RECOMMEND** that each patient call their insurance provider and verify network participation as well as covered physical therapy benefits and/or limitations.

Please know that every person is different and it is important to work as a team to get you optimal improvement. This requires communication, showing up to appointments, active participation and team work.

Signature: ____Date: ___________________

*** Disclaimer: Please note by providing your e-mail, you are also allowing Partners in Physical Therapy to e-mail you regarding clinic sponsored programs. However, please note you are able to opt out at any time. ***

• RECORDS • PRIVACY NOTICE • INSURANCE AUTHORIZATION • PATIENT RESPONSIBILITY •

I understand that as part of my health care treatment, ***Partners in Physical Therapy*** develops and maintains records containing my health information, which includes information about my health history, symptoms, test results, diagnosis, treatment, claims and payment information, etc. I understand that my health information will be used and disclosed by ***Partners in Physical Therapy*** for treatment, payment and health care operations and serves as:

- A basis for planning my care and treatment
- A means of communication among health professionals who may contribute to my care
- A source of information to bill for health care services rendered
- A means by which an insurance company or other third party payor can verify that services were billed and actually provided
- A resource for "health care operations" such as assessing quality and reviewing the competence of health care professionals

I have been provided with the link to the ***Partners in Physical Therapy*** Privacy Notice, which provides a more complete description to the use and disclosure of my health information (notice is located on our website: www.partnersinpt.com):

http://www.partnersinphysicaltherapy.com/uploadedFiles/File/privacyrights.pdf

I understand that I have the right to review the Privacy Notice prior to signing this consent form. I understand that ***Partners in Physical Therapy*** can change the terms of the Privacy Notice and that ***Partners in Physical Therapy*** reserves the right to make the new Privacy Notice provisions effective for my health information that it already maintains and uses, as well as for any health information that it may receive in the future.

I understand that if I refuse the sign this consent form allowing for the use and disclosure of my health information to carry out treatment, payment or health care operations, ***Partners in Physical Therapy*** may refuse treatment.

I understand that I have the right to request that ***Partners in Physical Therapy*** restrict how my health information is used or disclosed to carry out treatment, payment or health care operations, but such request may not be accepted. I request the following restrictions (N/A if none): ____

I understand that I may revoke this consent at any time by notifying ***Partners in Physical Therapy*** in writing, but if I do, it will not have any effect on uses or disclosures prior to the receipt of the revocation.

I give my consent to ***Partners in Physical Therapy*** to release my medical records to my referring physician, insurance company, third party insurance, or to my attorney.

I authorize my insurance company to pay directly to ***Partners in Physical Therapy*** proceeds payable under the terms of my policy. I understand and agree to pay any unpaid balance not covered by my insurance company; including those services that my insurance company may contend are not medically necessary. In the event my account is turned over to collection, I hereby agree to pay all collection cost and fees.

I understand that my insurance company may not cover all charges incurred at *Partners in Physical Therapy* and that insurance companies do not guarantee payment, therefore I will be responsible for these charges.

Patient/Guardian Signature __________________________________ Date: ____________________

Partners in Physical Therapy Intake Form

Name: ________________________ Date: ________ Date of Next MD Visit: __________

Occupation: _______________ Age: __________Height: __________ Weight: _________

Tell us why you are here:

____

What would you like your therapist to know?

____

What is your goal for physical therapy?

____

Tests/Medical Management:
Please list any tests or medical services that you have received for your chief complaint:

____

Allergies:

____

Current Medication: ☐ None

List Names of Medications:	Dose or strength:	How often taken:
1) ____________________	a. ____________________	b. ____________________
2) ____________________	a. ____________________	b. ____________________
3) ____________________	a. ____________________	b. ____________________
4) ____________________	a. ____________________	b. ____________________

Medical Condition History

Please list all medical conditions: ____
____

Please list all past surgeries: ____
____

Overall Health:

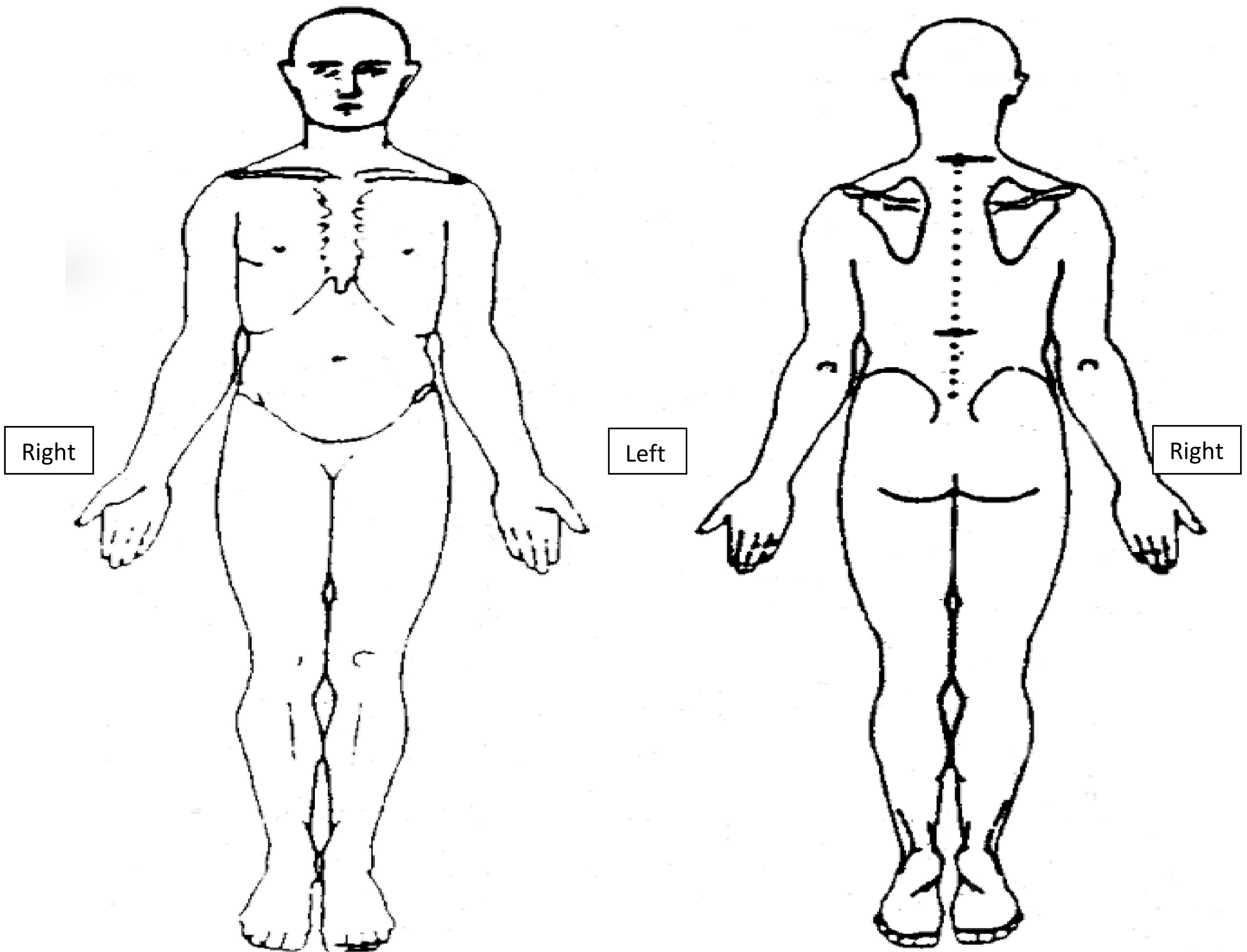
How would you rate your Overall Health?

☐Excellent ☐Good ☐Fair ☐Poor

Do you feel your job or home life is stressful?	☐Yes	☐No
Do you have periods of depression or sadness?	☐Yes	☐No
Do you have persistent fears?	☐Yes	☐No
Do you worry excessively?	☐Yes	☐No
Are emotional problems important to your current complaint?	☐Yes	☐No

Symptoms:

Please mark on the body your area of complaint using a highlighter:



Pain Intensity:
On a scale of 0 to 10 with 0 being no pain and 10 being the most severe pain imaginable:

Which number would describe your pain THIS WEEK?

What is your pain like NOW?	0	1	2	3	4	5	6	7	8	9	10
What is your LEAST pain?	0	1	2	3	4	5	6	7	8	9	10
What is your WORST pain?	0	1	2	3	4	5	6	7	8	9	10

Is your pain constant? ☐Yes ☐No **Is your pain worsening?** ☐Yes ☐No

Pediatric Patient Drop Off and Pick Up

Dear Parents,

In order to ensure the safety of our pediatric patients and follow HIPPA regulations:

- All pediatric patients must be signed in and out by a designated adult.
- The clinic will have a designated adult list for each patient and parents can feel free to add/delete individuals from the list as needed.
- All newly added adults will be required to show a picture ID on the first pick up date.
- Children will not be released unless the approved adult has physically signed the patient out.
- Children will not be allowed to wait for their designated adults in the lobby or outside of the facility.
- Due to HIPPA Regulations the designated adult may not enter the treatment area.
- Children must be supervised at all times. (i.e. restroom, lobby, etc.)
- Please arrive at the start of the treatment visit and be available at the ending time of the treatment visit for pick up to ensure that your child can have proper supervision.

Please understand that we take your child's safety seriously. Your understanding and cooperation is greatly appreciated. Feel free to contact us with any concerns or questions regarding this mandatory policy.

Sincerely,

Freddie Ann Regan,
Owner and Physical Therapist

Please list yourself and anyone allowed to pick up your child and relationship to child:

____

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____

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