

Patient Information Form

Name: _____ Hm Phone: _____ Cell Phone: _____

Employer: _____ Wk Phone: _____ Date Of Birth: _____

E-mail _____ Social Security #: _____

Home Address: _____ City: _____ Zip Code: _____

Spouse's Name: _____ Employer: _____ Wk Number: _____

Nearest Relative/Friend **not** living with you: _____ Phone: _____

Referring Physician: _____ Phone: _____

Primary Physician: _____ Phone: _____

Whom may we contact in case of an emergency?

_____ Phone: _____

Insurance Information

Insurance Company: _____ Phone: _____

Primary Insurance Policy Holder : _____ Date of Birth: _____

Employer: _____ Phone: _____ Social Security # : _____

Secondary Insurance: _____ ID#: _____

Name of Policy Holder: _____ Date Of Birth: _____

Worker's Comp Information / Attorney

Law Firm/ Worker's Comp Insurance: _____ Phone: _____

Claims Adjustor/Attorney: _____ Phone: _____

Claim/Policy: _____ DOI: _____

Notice Of Patient Information Practices

I have received and fully understand the MDR Physical Therapy's Notice of Privacy Practices. I understand that MDR may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that MDR will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in MDR's notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Signature: _____ Date: _____

Print Name: _____

To Our Patients Regarding Cancellations and No-Shows

The following are our policies regarding cancellations and no-shows. We take this subject seriously here at MDR, because it can make a difference between whether you succeed in your treatment or not. Showing up as scheduled for these visits is your most important priority. Other than that, all you need to do is follow your therapist's instructions and we will be able to achieve your goals in treatment.

- **If you miss three times without making the proper notification as stated above, you will be discharged from care.**
- For Worker's Comp. and Personal Injury patients, documentation of any missed appointment is forwarded to your Case Manager and Primary Physician, which could jeopardize your claim.
- Please understand that your pain will probably increase and decrease as your course of treatment progresses. Either condition can seem to be a good reason not to come in.
 - You're feeling worse and you think your treatment is not working as expected, come in and have it treated. Our Therapists have the tools and resources to help.
 - You're feeling better and it's a great day for golf, now is the perfect time to come in and begin education and correction of the underlying causes of your condition. (so they don't return)

Consent For Treatment / Insurance Authorization and Assignment

1. I or my representative, recognizing the need for care, consent to all services ordered or deemed appropriate by my physician and or physical therapist.
2. I hereby assign to MDR Physical Therapy all payments for Medical Services rendered to myself or my dependants. I understand that I am responsible for ANY amount not covered by insurance.
3. I understand that I am responsible for my co-payment/co-insurance, which is due at time of treatment, and any applicable deductible that has not been met.
4. I understand that cancellations **without 24-hour** notice or "**no-shows**" will be subject to a **\$25.00** office fee. Your insurance (even worker's comp) does not cover this fee.
5. **I understand that if my insurance company does not cover supplies utilized in my treatment I will be held responsible for them.**

I have read and understand all the information provided above. I also understand that I am ultimately responsible for the balance of professional services rendered. All the information I have given to MDR is true and correct to the best of my knowledge. I agree to notify MDR of any changes of my insurance and information provided.

Signature _____ **Date** _____
(Parent or Guardian, if a minor)