CONFIDENTIAL PATIENT INFORMATION

Name ____DOB ___________Age _______
Address ______________________________________Phone ____________________
City __________________State _____Zip_________Cell _____________________
E-Mail _______________________________________
☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Male ☐ Female
Social Security # _________________________D/L #________________________State
Employer ____ Phone
If a minor, Parent / Guardian _____________________ Phone_____________________

Primary Insurance ______________________________
Subscriber _____________________________________DOB ____________________
Social Security # _______________________________
Address ______________________________________Phone ____________________
City _______________________State ______Zip______

Secondary Insurance _____________________________
Subscriber _____________________________________DOB ____________________
Social Security # _______________________________
Address ______________________________________Phone ____________________
City _______________________State ______Zip______

Emergency Contact _____________________________Relationship _______________
Address ______________________________________Phone ____________________
City _______________________State ______Zip______

Referring Physician______________________________Next Visit _________________
Primary Care Physician _________________________ Next Visit _________________

I hereby authorize the release of any medical information necessary for processing insurance claims and payment of medical benefits for myself or the party who accepts assignment of benefit.

Signature____________________________________ Date _____________________

How did you hear about M&M Physical Therapy, LLC? ___________________________

Consent for Care and Treatment

I, the undersigned, do hereby agree and give my consent for M & M Physical Therapy, LLC to furnish medical care and treatment to __________________________ which is considered necessary and proper

patient name

in the diagnosing or treating of my (their) physical condition.

Signature ____ **Date** ________________

Patient / Guardian

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I, the undersigned, hereby assign all medical benefits, ie.: Medicare, private insurance, major medical benefits, Workers' Compensation and any other health plans to which I am entitled to M & M Physical Therapy, LLC. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize M & M Physical Therapy, LLC to release all medical information and records necessary to secure payment for services rendered.

Signature ____**Date** ______________

Patient / Guardian

FINANCIAL POLICY STATEMENT

It is our policy to bill your insurance carrier or other provider of medical benefits as a courtesy to you, although you are responsible for the entire bill when the services are rendered. Required co-payments and estimated co-insurances are to be made as services are rendered and arrangements are to be made for payment of all amounts not covered by your medical benefits or estimated co-insurances as soon as those amounts are known. If your medical benefits are not paid within sixty (60) days, the balance will be due in full from you.

If any payments of medical benefits are made directly to you for services rendered by M & M Physical Therapy, LLC , you must remit such payment directly to M & M Physical Therapy, LLC within 7 days of receipt.

All Co pays must be paid to M& M during the week treatment is provided.

If you are a Workers' Compensation patient the above policy does not apply to you. Be advised, however, that you may be responsible for your charges if your Workers' Compensation claim is successfully controverted.

If you fail to make timely payment for any amount for which you are responsible, you will be responsible for all costs of collection, including court costs, collection agency fees and/or a reasonable attorney fee.

I have read the above information and/or it has been explained to me and I accept the terms and conditions of the above and will be responsible for the payment of my account.

Signature Date ____ **Date** _____________________

Patient / Guardian

Patient Privacy Policy & Procedure Statement

Dear Patient:

M & M Physical Therapy, LLC maintains compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy regulations passed into law on December 20, 2000.

We obtain your voluntary consent to provide treatment, release medical records to the appropriate entities and those who you designate to provide health care treatment, payment, and daily operations of the facility.

Our clinical and front office staff uses patient information to ensure quality care and appropriate billing for services.

You may correct, amend, access, and request a copy of your medical record and access history by signing a letter for release of your medical information. The cost for copies of medical records is in accordance with state law.

We protect all patient information within the guidelines provided by federal, state, and local government.

I hereby give permission to discuss my health and billing information with the following.

Name:________________Relationship:_________________ Phone #____________

Name:________________Relationship:_________________ Phone #____________

If you have any grievance pertaining to the privacy of medical records or wish to inquire further about how our facility manages patient information, please contact our Privacy Officer at 856-234-4600.

M & M Physical Therapy, LLC reserves the right to amend, change, and/or revise our privacy policy at any time in accordance with federal, state, and local rules, regulations, and guidelines.

By signing I am stating that I have received a copy of the Patient Privacy Policy and Procedures Statement. I have the right to withdraw or revise my permission at any time.

Thank you for choosing our health care facility.

Signature ______________________________ Date _______________

Patient / Guardian

Confidential Medical Information

Please state current problem(s): ____

____

Are you currently being treated by:

Another Therapist ____ Yes____ No Or within the last 12 months ___ Yes ____ No

Chiropractor / Osteopath ____ Yes____ No Or within the last 12 months ____ Yes ____ No

Home Health Agency ____ Yes____ No Or within the last 12 months ____ Yes ____ No

Major Surgeries Since Birth: ____

Allergies: ____

Do you smoke? ☐ YES ☐ NO

Check if you have or previously had any of the following:

☐ Arthritis

☐ Asthma

☐ Cancer

☐ Circulation Problems

☐ Diabetes

☐ Heart Problems

specify:____

____

☐ High Blood Pressure

☐ Gout

☐ Seizures

☐ Stroke

☐ Ulcers

☐ Other Illnesses

specify:____

____

The above information is true and accurate to the best of my knowledge. I hereby authorize the release of any medical information necessary for processing insurance claims and payment of medical benefits for myself or the party who accepts assignment of benefits.

Signature:______________________________ Date:_______________

Patient Name____ Date________________________

Current Medication List

Please list all current medications, including prescription, over the counter, vitamin/mineral/dietary supplements, and herbals, including all information below, or attach list.

Medication Name	**Dosage**	**Frequency**	**Route of administration**

Patient Name____ Date________________________

Patient Questionnaire: Patient Specific Functional Scale (PSFS) - Initial Assessment

We want to know what 3 activities in your life you are unable to perform, or are having the most difficulty performing as a result of your chief problem. Please list and circle the rating for at least 3 activities that you are unable to perform, or are having the most difficulty performing because of your chief problem.

Rating Scale: 0 (I am unable to perform the task → 10 (I am able to perform the task very easily)

1. ____

Rating: 0 1 2 3 4 5 6 7 8 9 10

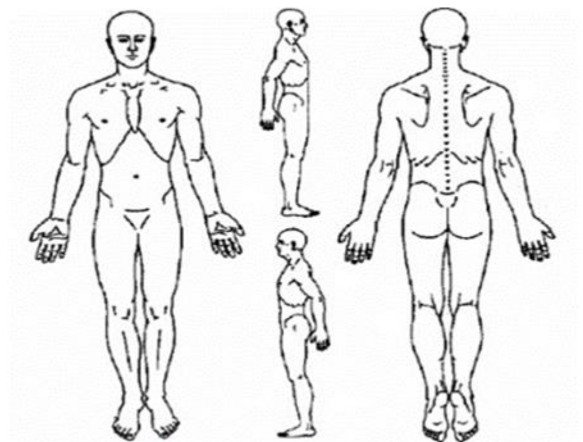
2. ____

Rating: 0 1 2 3 4 5 6 7 8 9 10

3. ____

Rating: 0 1 2 3 4 5 6 7 8 9 10

Using the diagram to the right, mark areas on your body where you feel your symptoms (pain, numbness, tingling, burning, etc). Mark areas of radiation. Include all affected areas.



Rate your pain by circling the one number that best describes your pain TODAY.

0	1	2	3	4	5	6	7	8	9	10

Have you had two or more falls, or one fall resulting in injury, over the past year?

YES ☐ NO ☐