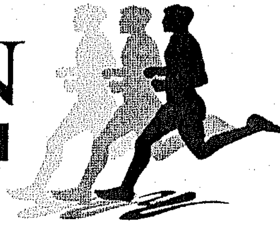
RATHJEN
PHYSICAL THERAPY



Name:____

Home Address:______________________________________

City:____________________ State:__________ Zip:__________

Home #:______________ Cell #:______________ Work #:______________

Email:____

Social Security # (Required):____________________ Sex: M / F

Birth Date:____________________ Age:__________

Emergency Contact:____________________ Home #:____________________

Relationship:______________ Cell #:______________ Work #:______________

How did you hear of Rathjen Physical Therapy?____________________

Physician:____

Insurance Card Holder's Name:____________________ Birth Date:______________

Employer: Company Name:______________________________
Address:______________________________
City, State & Zip:______________________________

Work Injury / Auto / Neither (circle one) Date of injury:____________________

If workman's compensation claim, did you file an accident report? Yes / No

Signature:______________________________ Date:______________

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Patient Medical History

Name: ______________________________ Date:____________ Next Physician Appointment:______________

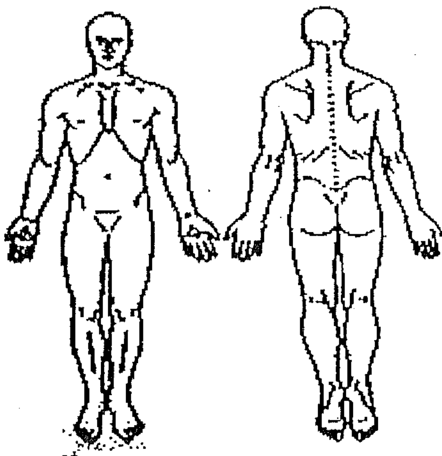
Was this problem a result of injury? Yes No

Have you had a recent flare-up or increase in your symptoms? Yes No

Have you had or do you have any of the following?

Diabetes	Yes	No
Chronic Headaches	Yes	No
Previous Physical Therapy	Yes	No
Dizziness	Yes	No
Currently Pregnant	Yes	No
Chiropractic Visit	Yes	No
Massage Therapy	Yes	No
Cortisone Allergies	Yes	No
Pacemaker/Defibrillator	Yes	No
Cancer	Yes	No
Allergic to Latex	Yes	No

Please circle on the scale below your level of pain today.



0 = No Pain 10 = Pain that would make you go to the emergency room

1 2 3 4 5 6 7 8 9 10

Please indicate on the drawing the location(s) of your pain:

AUTHORIZATION FOR RELEASE OF INFORMATION AND CONSENT TO TREAT

The undersigned hereby authorizes ***Rathjen Physical Therapy*** to furnish from my medical record requested information or excerpts to the referring physician, if any, and to Medicare, Medicaid, or any insurance company for the purpose of processing claims and to obtain payment of the account for services provided to the patient. By signing, this authorization the patient, parent, or legal guardian of the patient hereby gives consent to medical treatment.

MEDICARE RELEASE

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any authorized benefits be made on my behalf.

FINANCIAL AGREEMENT

The undersigned hereby agrees that, in consideration of the services to be rendered to the patient, to pay ***Rathjen Physical Therapy*** in accordance with the regular rate and the offices payment policy. These are billable services and are due by the patient. **A late fee will be charged to all overdue account balances after 60 days.**

Auto Accident

Patient's claims will first be filed with Motor Vehicle Insurance. Any charges outstanding 60 days are the responsibility of the patient and will be billed accordingly.

WORKMAN'S COMPENSATION

PLEASE NOTIFY RECEPTIONIST IF THIS IS A WORKMAN'S COMPENSATION INJURY.

Any patient claiming worker's compensation must bring notice of injury from there employer before it will be turned into workman's compensation insurance. Otherwise all billing will be submitted to personal medical insurance.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE FOREGOING, AND IS THE PATIENT OR IS DULY AUTHORIZED BY OR ON BEHALF OF THE PATIENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS.

______________________________ ______________________________

Patient or Parent/Legal Guardian's Signature **Date**

RATHJEN
PHYSICAL THERAPY

Notice of Information Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

Rathjen Physical Therapy, LLC. Is required by federal law to maintain the privacy of Protected Health Information and to provide notice of its legal duties and privacy practices with respect to Protected Health Information. This notice fulfills the "Notice" requirements of the Health Information Portability and Accountability Act of 1996 (HIPAA) Final Privacy Rule. If you have questions about any part of this Notice of Information Privacy practices or desire to have further information concerning information practices at Rathjen Physical Therapy, LLC. Please call us at 308)381-2424.

Acknowledgement of receipt of this notice: I have been informed of the Privacy Policies of Rathjen Physical Therapy, LLC.

______________________________ Signature of Recipient

______________________________ Date