RATHJEN
PHYSICAL THERAPY

3213 W. North Front Street
Grand Island, NE 68803-4028
Phone – (308) 381-2424
Fax – (308) 381-3646

Today's Date: _____/_____/ 20_____

Patient Information

Patient Name	Last:	First:	Middle:
Nickname:		Birth Date:	Gender: Male ☐ Female ☐
Mailing Address:			
City:		State:	Zip Code:
Marital Status:	Home Number:	Cell Number:	Email: Statement: Yes ☐ No ☐

Employment Information

Current Employer:	
Work Phone:	Job Title:

Emergency Contact Information

Name:	Relationship:	Phone:

Injury Information

Reason for visit:			
Accident Related: Y ☐ N ☐	Injured in Home: Y ☐ N ☐	Work Related Accident? Y ☐ N ☐	Injury Date:
Auto Accident: Y ☐ N ☐ If Yes, date/time of accident?		If Yes, what state?	
Working with a Lawyer? Y ☐ N ☐	Name:	Phone:	
Date symptoms began?	Date of Surgery (if Applicable)?		

Referring Doctor:

Have you had Physical, Occupational, or Speech Therapy services **in the past calendar year**? Y ☐ N ☐	Have you had Chiropractic services **in the past calendar year**? Y ☐ N ☐
Name of Facility:	

Insurance Information

Primary Insurance Carrier:		
Policy Holder Name:	Birth Date:	
Policy ID Number:	Group Number:	Relationship:
Secondary Insurance Carrier:		
Policy Holder Name:	Birth Date:	
Policy ID Number:	Group Number:	Relationship:

Work Comp / Auto Insurance Carrier:			
Address:	City:	State:	Zip:
Claim #:	Case Manager :	Phone #:	
Employer Contact Name & Phone#:			

Insurance

We assume no liability for any errors made by your insurance carrier(s) in their quotation of benefits, as it is not a guarantee of payment. It is your responsibility to understand the benefits and limitation of your insurance policy and clarify any discrepancies in eligibility, benefits and/or authorization and inform our clinic immediately. Your insurance policy is a contract between you and your insurance plan. We cannot efficiently bill your insurance company unless you provide us with current and valid insurance information. In the event that your health plan determines that a service is "not covered" you will be responsible for the entire charge. It is your responsibility to notify our office when either your insurance plan or benefits change. Any cost incurred by this office because of incorrect information you provided to us will be passed on to you. We have reviewed these benefits with you. You understand and agree to pay any balance remaining after your insurance carrier(s) has paid its portion of the charges. Our insurance contracts require us to collect co-payments, co-insurance and deductible amounts at the time of services. These amounts will be collected prior to services being rendered. _____(initials)

Auto/Liability Claims

Our policy is to file liability claims on behalf of our injured patient. However, if a denial is received or if your claim is not settled we will ask that you begin making regular monthly payments. Failure to make regular payments may result in your account being turned over to collections. We will also submit to your health insurance for payment if a denial is received or the claim is not settled in a timely manner. We will work with you to establish a reasonable monthly or weekly payment plan to accommodate your needs. If an attorney is involved, this does not releases your responsibility in making the required monthly payments. _____(initial)

Workman's Compensation

Our policy is to file with the worker's compensation insurance company on behalf of our injured patient. However, if a denial is received from the worker's compensation insurance company or if your claim is not settled, we require private insurance information and will file these claims on the patient's behalf. Any balances due at that point will be patient responsibility. Failure to make regular payments may result in your account being turned over to a collection agency. We will work with you to establish a reasonable monthly or weekly payment plan to accommodate your needs. If an attorney is involved, this does not releases your responsibility in making the required monthly payments. _____(initial)

Appointments

Our goal is to provide the best possible care and provider availability to each of our patient. Our policy is to request you to call and cancel appointments 24 hours prior to scheduled appointment. Please call us, as early as possible, when you know you will need to reschedule and/or cancel an appointment. If 3 appointments are missed without prior notification, you will be unable to schedule future appointments. _____(initial)

Information

I hereby agree that the enrollment information provided is correct. I also agree that any changes to the enrollment information will be communicated to **Rathjen Physical Therapy, LLC** as required to fulfill the medical and financial obligation for services rendered. _____(Initials)

Authorization

I hereby request and consent that my medical records and non-written records be sent to my referring providers, those providers or ancillary facilities that I am referred to by **Rathjen Physical Therapy, LLC** and to my insurance company or its agents. I further understand that my medical records may contain sensitive information and hereby authorize the release of all confidential HIV related information, communicable diseases related information, drug and alcohol abuse/treatment information and mental health diagnosis/treatment information to **Rathjen Physical Therapy, LLC**.

I hereby authorize my consent to **Rathjen Physical Therapy, LLC** for my medical treatment. I consent to payment directly from my insurance carrier to **Rathjen Physical Therapy, LLC**. If a self pay patient; I am responsible to pay at the time of service.

X	**X**
Patient Name (**please print**)	Date of Birth
X	**X**
Signature of Patient (and/or Legal Guardian)	Today's Date
X	**X**
Witness Signature	Today's Date

RATHJEN
PHYSICAL THERAPY

3213 West North Front St
Grand Island, NE 68803

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 or request a copy at the time of your visit.

Acknowledgement of receipt of this notice:

I have been informed of the Privacy Policies of Rathjen Physical Therapy, LLC.

X_____

(Please Print) Name of Recipient

X_____ X_____

Signature of Recipient Today's Date

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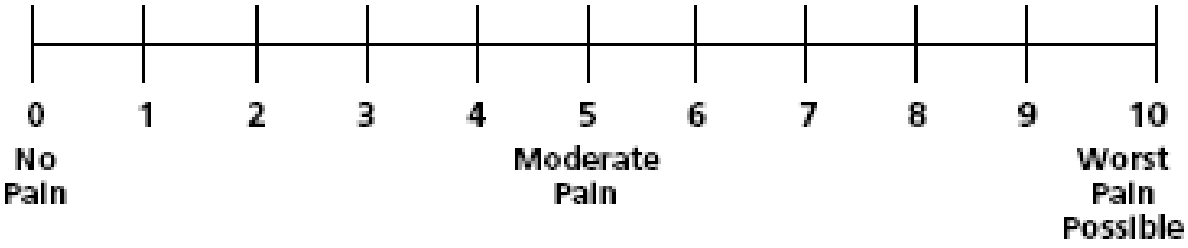
Please circle the number that best describes your current pain level.

*0 – 10 Numeric Pain Intensity Scale**



Please indicate on the drawing below, the location(s) of your pain.