DYNAMICS
PHYSICAL THERAPY
SPINE, SPORTS & ORTHOPEDICS

Patient Information

Last Name _____ **First name**_____ **MI** ___

Address _____
Mailing/Physical Address **City** **State** **Zip Code**

Home Phone _____ **Cell Phone** _____

Date of Birth _____**SSN#** _____ **Email Address**_____

Marital status: ☐ **Single** ☐ **Married** ☐ **Other** **Sex:** ☐ **Male** ☐ **Female**

_____ _____
Emergency Contact Name **Relationship to Patient** **Telephone number**

Employer _____ **Work Phone** _____ **Ext** _____

Referring Physician: _____ **Primary Physician:** _____

Insurance Coverage Information (Please present your insurance card (s) to the front desk)

Primary Insurance _____

Name of Insured _____
(if self, please put "self)

Insured Date of Birth _____

Insured ID # _____

Group # _____

Group Name _____

Secondary Insurance _____

Name of Insured _____
(if self, please put "self)

Insured Date of Birth _____

Insured ID # _____

Group # _____

Group Name _____

I hereby authorize payment of medical benefits for all covered services to be paid directly to DYNAMICS PHYSICAL THERAPY. Every effort will be made to manage insurance benefits on my behalf, however the primary focus will be on my physical care. I understand that co-payments, co-insurance, etc. will be due at time services are rendered. I accept financial responsibility for any service(s) provided to me not covered by my insurance policy. If a payment plan is necessary for any balances due, I will contact the office immediately to make payment arrangements. I have read and understand the financial policy. No shows & late cancellations will carry a $30 fee and are not billable to my insurance company. A copy of the Privacy Policy is available for review upon request. This practice accepts cash, checks, money orders, VISA, MC, AMEX and Discover.

How did you hear about us?

- ❑ **Family\ Friends**
- ❑ **Internet**
- ❑ **Insurance Listing**
- ❑ **Doctor\ Referral**
- ❑ **Former Patient**
- ❑ **Other**

_____
Signature (***If minor, parent signature is required***)

_____
Date

I authorize the release of my medical and billing information to the following:

_____ _____
Name Date

_____
Relationship to patient

_____ _____
Name Date

_____
Relationship to patient

DYNAMICS PHYSICAL THERAPY FINANCIAL POLICY

DYNAMICS PHYSICAL THERAPY is committed to providing you with the highest level of quality medical care and personal service. ***DYNAMICS PHYSICAL THERAPY*** does everything possible to make our patients our priority including working to hold down the costs of healthcare. We believe that it is the patient /guardian's responsibility to meet the financial obligations made with both your insurance company and our practice.

The following is a summary of our financial policies.

1. New patients must complete registration forms prior to or at the time of his or her appointment. Registration forms are updated annually.
2. Proof of identity and insurance must be provided at first appointment. Patient will assume all cost for services provided if failure to provide said information.
3. In the event we are unable to verify insurance benefits, patient will assume all cost to be paid at time services are rendered unless arrangements are made with ***DYNAMICS PHYSICAL THERAPY.***
4. Payments for services may be made by Cash, Check, Money Order, VISA/MC, AMEX or Discover Card.
5. If a physician referral is required by your insurance carriers, please facilitate this process before your first appointment.
6. Missed appointments represent a cost to ***DYNAMICS PHYSICAL THERAPY***, as well as you, and to other patients. **Cancellations require a minimum 24-hour notice.** Excessive abuse of scheduled appointments will result in a fee of $30 and/or discharge from the practice.
7. ***A $30 fee will be billed to the patients who no show for scheduled appointments. No show fees must be paid prior to the next scheduled appointment.***

Insurance

8. ***DYNAMICS PHYSICAL THERAPY*** will file claim(s) with your insurance. All contracted co-payments, coinsurance and deductible amounts will be collected at the time of service.
9. As your health care provider, our relationship is with you, not with your insurance company. It is each patient's responsibility to comprehend his/her insurance coverage. While filing of insurance is a courtesy we extend to our patients, all charges remain the patient's responsibility.
10. **Verification of your benefits is not a guarantee of payment**. All payments are subject to the terms and conditions of your individual plan.
11. If payment is not received within 45-days of submission, or if a denial is received by your insurance company, we reserve the right to bill you directly for the services provided.
12. Statements will be generated when your claims are internally processed, or the balance exceeds the 45-day maximum allowance for outstanding balances. ***Statement balance amounts will be due within 30-days of statement date.*** If you find an error on your statement or have any questions, please contact us immediately to clear up any confusion or concerns.

Credits & Overpayments / Returned Checks

13. Payments taken on the date of service are applied as credit to your account. These credits will be applied to outstanding balances once your insurance has processed.
14. Additional credits will remain on your account to be used for future visits and until insurance settlements are completed. Overpayments will be refunded within 120 days upon request.
15. Returned checks will incur a $30.00 service charge. Payment for return checks and services are due upon the notice of the returned check and are payable by cash, money order, VISA/MC, AMEX or Discover ONLY. ***DYNAMICS PHYSICAL THERAPY*** reserves the right to refuse payment by check if a history of returned checks is established.
16. All accounts not paid within 90-days of the due date may be turned over to a Collections Agency and documented on your credit report. Accounts reported to the credit bureau are subject to additional fee (s) which will be added to the total balance due and become your responsibility. Past due balances of over $200.00 may be taken to small claims court.

I have read, understand and agree to comply with the Financial Policy as stated above. I agree to allow ***DYNAMICS PHYSCIAL THERAPY*** to file claims on my behalf and receive payment for those services as governed by contract.

_____

Patient Name (Print)

_____ _____

Patient Signature ***Date***

788 Prince Avenue, Ste C, Athens, GA, 30606 ***www.dynamicspt.com*** ***(***706) 543-2111 ph. / (706) 543-2190 fax

DYNAMICS PHYSICAL THERAPY
SPINE, SPORTS & ORTHOPEDICS

MEDICAL HISTORY

Name _____ **Today's Date** _____

Referring MD _____ **Next Appointment** _____

When did you first notice the pain? _____

On a scale of 0 - 10 (0 = no pain, 10 = worst pain you can imagine), rate the following:

Worst pain thus far : _____ **Least pain thus far :** _____ **Today's pain :** _____

For this condition, have you seen any of the following ?

□ Medical Doctor From _____ **to** _____ **□ Physical Therapist From** _____ **to** _____

Therapist's Name _____ **Location** _____

List any diagnostic tests that you have had for this condition (X-ray, MRI, etc..) _____

Do you have any medical problems that would limit your ability to exercise? □ Yes □ No If yes, please explain:

_____

Please describe any surgeries in the past: _____

_____

What do you hope to accomplish with therapy? _____

_____

Injury Work Related? □ Yes □ No Injury the result of an auto accident? □ Yes □ No

Are you currently working? □ Yes □ No If yes, how much? □ Full Duty □ Restricted Duty

How many work days have you missed? _____ **Do you have a case manager? □ Yes □ No**

Case Manager's Name: _____ **Phone #** _____

Please list your work duties. _____

What critical work duties have been affected by your injury / condition? _____

_____

Have you ever been diagnosed with any of the following?

Tuberculosis	□ Yes	□ No	**Stroke**	□ Yes	□ No
Heart Condition	□ Yes	□ No	**High / Low Blood Pressure**	□ Yes	□ No
Pregnancy (current)	□ Yes	□ No	**Vision / Hearing Problems**	□ Yes	□ No
Dizzy / Fainting spells	□ Yes	□ No	**Arthritis**	□ Yes	□ No
Epilepsy	□ Yes	□ No	**Hepatitis**	□ Yes	□ No
Cancer	□ Yes	□ No	**Diabetes**	□ Yes	□ No
Breathing Problems	□ Yes	□ No	**Rheumatic Fever**	□ Yes	□ No
Pacemaker	□ Yes	□ No	**Angina or Chest Pain**	□ Yes	□ No
Back Injury	□ Yes	□ No	**Kidney Problems**	□ Yes	□ No
Disease of the arteries	□ Yes	□ No	**Disability of feet / ankles**	□ Yes	□ No
Asthma	□ Yes	□ No	**Swollen and stiff painful joints**	□ Yes	□ No
Lung Disease	□ Yes	□ No	**MRSA infection**	□ Yes	□ No
Shortness of Breath	□ Yes	□ No	**VRE infection**	□ Yes	□ No

If you checked any of the above, please explain : _____

_____

_____

_____

Please list any other medical conditions: _____

_____

Please list all medications that you are currently taking:

Medications	Reason for medication	Dosage	Frequency & How Taken

Are you allergic to any medications? _____

_____

Other allergies? _____

_____

Have you had any X-Rays/MRI's that are related to the condition you are being seen for today?
□ Yes □ No

****If YES, please proceed to fill out this form so that we can request those records****

Where did you have the x-ray/MRI done?

□ Athens Diagnostic Center	**□ Piedmont Healthcare System**	**□ St. Mary's**
□ AOC	**□ MRI and Imaging of Athens**	**□ Other**

****Other** _____

DYNAMICS PHYSICAL THERAPY
788 Prince Avenue Ste. C
Athens, Ga. 30606
706-543-2111
Fax 706-543-2190

Authorization for Disclosure of Protected Health Information

I hereby authorize_____ to release *X-Ray/MRI* reports to DYNAMICS

PHYSICAL THERAPY. A copy shall be as valid as the original document.

I understand that when my PHI is disclosed pursuant to this Authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing, except (1) to the extent that the Practice has acted in reliance upon this Authorization (2) to the extent that the Authorization was obtained as a condition of obtaining insurance coverage, there is other law that grants the insurer the right to contest a claim under the policy. I understand that my revocation must be submitted in writing to the Practice's Privacy Official/Committee at 788 Prince Ave. Suite C Athens, Georgia 30606, by sending a written request stating that I wish to revoke this Authorization to the attention of the Privacy Official/Committee. I understand that the Practice may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization. By signing this authorization, I authorize **DYNAMICS PHYSICAL THERAPY** (the "Practice") to use and/or disclose certain protected health information (PHI) to or for the party or parties listed above.

Print Patient's Name: _____

Date of Birth: _____**/**_____**/**_____

Signature_____
Signature of Patient or Personal Representative

Date: _____

If signed by a Personal Representative, please state authorization to do so:

_____