



Solutions To Pain and Functional Limitations

http://www.GlobalPT.org

1-800-664-7422

Patient Information Sheet

Referring Physician's Name: Appt. Date: License #: UPIN #: NPI #: Medicaid ID #:

PATIENT INFORMATION (please print):

Patient Full Name (First, Last): Address: Street City State Zip SS#: Date of Birth: Sex: Home Phone: Work/Cell Phone:

Emergency Contact: Relationship: Phone Number:

Marital Status (circle One): Single Married Divorced Separated Widowed

Employers Name and Address:

INSURANCE INFORMATION:

Is this injury auto related: YES/NO Is this injury work related: YES/NO Primary Insurance Name: Card Holder: Card Holder SS#: DOB: Contract Number: Group Number:

Secondary Insurance Name: Card Holder: Card Holder SS#: DOB: Contract Number: Group number:

AUTO or WORKER'S COMPENSATION information:

Insurance Name and Address: Phone Number: Claim Number: Rep. Name:

MEDICARE INFORMATION:

Is your spouse working? If so please input insurance information for billing purposes:

I the undersigned have insurance coverage with and assign directly to Great Lakes Orthopedic Physical Therapy, Inc. DBA Global Physical Therapy all surgical and/or medical benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. If I am to receive checks from my insurance company it will be my responsibility to render monies received to Great Lakes Orthopedic Physical Therapy, Inc. DBA Global Physical Therapy within one day. I hereby authorize Great Lakes Orthopedic Physical Therapy, Inc. DBA Global Physical Therapy to release all information necessary to secure the payment of benefits. I hereby authorize this provider to release my current and future medical records from them to unless the authorization to release is terminated or modified by me. Photocopies of this form to be valid as original.

Patient's Signature: Date:

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38300 Van Dyke Ave., Suite 101 Sterling Heights, MI 48312 Phone: (586) 977-5700 Fax: (586) 977-5704

300 West Washington Avenue, Suite 055 Jackson, MI 49201 Phone: (517) 782-6385 Fax: (517) 782-6386

Email: peter@globalpt.org



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Social Worker Services

We are interested in the total well being of our patients. In keeping with this philosophy, we feel that a social worker's intervention may sometimes be appropriate. During your rehabilitation you, your physician, your therapist, or your social worker may feel that this service may be helpful. The social worker is available by appointment to evaluate the social or vocational factors involved in your rehabilitation, to counsel and advise you on your problems arising from your illness or injury, and to make appropriate referrals for required services if any are needed. You may schedule a meeting with our social worker through the receptionist or through your therapist. If you are receiving any State Services through the DHS please contact your case worker.

Please indicate your choice: YES \_\_\_\_\_ NO \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Social Worker Assessment (OFFCIE USE ONLY)

Patients Name: \_\_\_\_\_ Date Admitted: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

It is my professional opinion that the patient's physical illness or injury DOES/DOES NOT (circle one) demonstrate a need for social/ vocational adjustment services.

This determination is based upon a review of the following:

- \_\_\_ Patient Intake Profile/ Patient Information Sheet
\_\_\_ Social Work Service Information Form
\_\_\_ Therapy Evaluation and Progress Notes
\_\_\_ Physicians Referral Notes or Prescription
\_\_\_ Demographic information from insurance verification form/Patient information form
\_\_\_ Discussion with Evaluating Therapist
\_\_\_ Discussion with External Case Manager (if any)

Problems (if any) \_\_\_\_\_

Signature/ Title: \_\_\_\_\_ Date: \_\_\_\_\_

\* Notations of follow-up activities are made on the reverse side of this form.

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HIPPA Authorization Form

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Street City State Zip

Home Phone#: ( ) \_\_\_\_\_ Work/Cell Phone#: (

) \_\_\_\_\_

SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) described below who I am authorizing to use and/or disclose my health information may not condition treatment, payment, enrollment in a health plan, or eligibility for healthcare benefits on my decision to sign this authorization.

- 1. I authorize the following health information to be used and/or disclosed : Physical Therapy Records
2. I authorize the following person(s)/organization(s) to use my health information: Insurance - Doctors - Global Physical Therapy Staff
3. I authorize the following person(s)/organization(s) to receive and/or use my health information: Same as Above
4. I authorize my health information to be used and/or disclosed for the following purpose(s): Physical Therapy Billing
5. My Right to Revoke this Authorization: I understand that I have the right to revoke this authorization at any time. I also understand that my revocation of this authorization must be in writing. To obtain a copy of an authorization revocation form I may contact: Global Physical Therapy. I am aware that my revocation will not be effective if (I) this authorization was obtained as a condition for obtaining insurance and applicable law permit's the insurer to contest the claim or the policy itself or (II) to the extent the person(s) and/or organization(s) identified above have already acted in reliance upon this authorization.
6. Redisclosure of My Health Information: I understand that if the person(s) and/or organization(s) listed above are not healthcare providers, health plans, or healthcare clearing houses that are subject to the Federal privacy standards, the health information disclosed pursuant to this authorization may no longer be protected by the Federal privacy standards and such person(s) and/or organization(s) may redisclose my health information without obtaining my authorization.
7. Disclosure of direct or indirect remuneration received by any person and/or organization authorized to use and/or disclose my health information: I understand that Global Physical Therapy will be receiving direct or indirect remuneration in connection with the use and/or disclosure of my health information.
8. Expiration of authorization: This authorization will be effective until the following date or event:

\_\_\_\_\_  
Patient Signature Date

If patient is unable to sign, complete the following:

Patient is unable to sign because: \_\_\_\_\_

\_\_\_\_\_  
Authority of Representative Name and relationship to patient  
(power of attorney, Guardian, other statutory authorization)

Address: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

\_\_\_\_\_  
Signature of Personal Representative Date

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HIPPA Form

<b>Receipt of Notice of Privacy Practices</b>	
Patient Name: _____ Medical Record #: _____	
<p>My signature on this form acknowledges that I have received a copy of the Notice of Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by the (practice) and of my rights with respect to my health information.</p> <p>I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information.</p>	
_____ Patient Signature	_____ Date
_____ Signature of Patient's Representative (if patient is unable to sign)	_____ Date
<b>To Be Completed By Employee If Form Is Not Signed</b>	
1. Was the patient provided with a copy of the Notice of Privacy Practices? YES _____ NO _____	
2. Briefly describe efforts made to obtain the patient's acknowledgement of receipt of the Notice and explain why the patient was not able or willing to sign this form: _____ _____ _____ _____	
_____ Employee Signature	_____ Date

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Attendance Policy

We at Global Physical Therapy are pleased that you have selected one of our facilities to participate in your Plan of Care and your healing process. Our therapists and staff are committed to assisting you through the therapy process and returning you to the highest function prior to discharge from your Plan of Care.

To help us in assisting you toward your goals, we will require that you comply with your Home Exercise Program and attend the appointments scheduled in a very consistent manner. We at Global Physical Therapy consider the appointments which you schedule are your responsibility to attend and that it is your own best interest to attend. By not attending you are not only affecting yourself and your outcome, but also others whom may have required that appointment time to meet their respective goals. This will help us to serve the community in the most effective and constructive way.

Therefore an Attendance Policy has been established and is as follows:

1. Failure to attend a scheduled appointment will result in a \$25.00 missed appointment fee if we are not notified 24 hours in advance.
2. Appearing at a time other than your scheduled appointment time may result in the inability to receive your therapy either partially or in its entirety, however we will try to accommodate you to the best of our ability but without jeopardizing others care.
3. Missing three (3) scheduled appointments may result in discontinuance of your Physical Therapy program due to non-compliance to the physician approved Plan of Care and notification of your physician and insurance company.

Again, Global Physical Therapy would like to see you achieve the best possible outcome from your therapy and appreciate your agreement to this policy by signing the statement listed below.

I, \_\_\_\_\_ agree to all fees associated with late and missed appointments as set forth in the statements listed above and pay them promptly. I agree that my Plan of Care may be discontinued secondary to missed appointments and non-compliance to my Plan of Care which is stated above.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

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## Medical Records Release Form

Date:

Patient Name:

I hereby authorize \_\_\_\_\_ to release my entire medical records to \_\_\_\_\_.

This authorization covers current and future requests from them, unless authorization is terminated or modified by me.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

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