Global Physical Therapy

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:** _____

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**

Knowledge • Experience • Results

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HIPPA Form

Receipt of Notice of Privacy Practices

Patient Name: _____
Medical Record #: _____

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.

I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information.

_____ _____
Patient Signature Date

_____ _____
Signature of Patient's Representative Date
(if patient is unable to sign)

To Be Completed By Employee If Form Is Not Signed

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 it's 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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