2020 PATIENT INFORMATION

Welcome to **Léger Physical Therapy!** Thank you for selecting our practice for your physical therapy needs.
In order to serve you properly, we will need the following information.

PATIENT NAME: ____DATE:___________________________

IF Patient is a CHILD, PARENT/GUARDIAN'S NAME(S): ____

STREET ADDRESS: _______________________________ CITY: ____________________ STATE: ______ ZIP: ________

HOME#: ___________________________ CELL#: __________________________ WORK#: ______________________

EMAIL ADDRESS:____ DATE OF BIRTH: ______________________

REFERRING PHYSICIAN: ____ PHONE#: ____________________________

STREET ADDRESS: ____________________________ CITY: _____________________ STATE: ______ ZIP: ____________

IN CASE OF AN EMERGENCY, PLEASE PROVIDE THE FOLLOWING INFORMATION

NAME:_____________________________ PHONE#: ________________________ RELATIONSHIP: __________________

NAME:_____________________________ PHONE#: ________________________ RELATIONSHIP: __________________

2020 PAYMENT AND FEE POLICY

Thank you for choosing Léger Physical Therapy. Your symptom recovery is our highest priority. It is important to us that you fully understand our payment policy. Please read thoroughly and feel free to ask any questions about your payment responsibilities. All business forms are required to be signed and dated prior to any services rendered in 2019.

Physical Therapy Evaluation and Re-Evaluation Hour	**$215**
Physical Therapy Treatment Hour	**$190**

1. Methods of payment are cash, check, Visa, Master Card, Discover, and American Express.
2. A $50 fee is charged for all checks that are returned due to insufficient funds.
3. A Processing fee of 4% will be added to all debit and credit transactions.
4. For Non-Medicare patients, Léger Physical Therapy does offer an incentive to patients who are able to pay for Physical Therapy treatment hours at the time of service. This 'SAME DAY PAYMENT DISCOUNT' is $20 off of each Physical Therapy treatment hour paid in full at the time of service. This incentive does not apply to Physical Therapy Medicare patients. It also no longer applies to hours with Dr. Sue Leger.
5. All Persons are required to pay their plan's designated co pay upon date of service.
6. All patient accounts with unpaid services reaching 90 days past date of services will be handled as follows:
   a. All scheduling of services will be immediately suspended.
   b. Immediate payment of a minimum of ten percent of total amount due will be required.
   c. Subsequent monthly payments of a minimum of ten percent of remaining balance will be required until account is paid in full.
   d. Failure to comply will result in collection processing.

I have read thoroughly and agree to abide by the above Payment Policy.

PATIENT NAME (printed):____

SIGNATUREOF RESPONSIBLE PARTY:______________________________________

Relationship to Patient:____

PRINT NAME: ________________________________DATE_____________________
(If other than Patient)

WITNESS:____

Revised 12-1-19

2020 Notice of Privacy Practices

NAME OF PATIENT: ____

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

Acknowledgment of Physical Therapy Diagnosis

A Physical Therapy diagnosis is not a medical diagnosis by a physician or based on radiological imaging and such services might not be covered by health plan or insurance."

PATIENT NAME (printed):____

SIGNATUREOF RESPONSIBLE PARTY:______________________________________

Relationship to Patient:____

PRINT NAME:____________________________DATE:_____________________
(If other than Patient)

WITNESS:____

Revised 12-1-19

2020 HIPAA AUTHORIZE RELEASE OF YOUR MEDICAL RECORDS

NAME OF PATIENT: ____

PLEASE LIST ANY INSURANCE COMPANIES AND/OR HEALTH CARE PROVIDERS THAT YOU WOULD LIKE TO AUTHORIZE RELEASE OF YOUR MEDICAL RECORDS TO UPON THEIR REQUEST.

I Authorize **Léger Physical Therapy** to release pertinent clinical and account information to the following **insurance companies** to facilitate my reimbursement:

1. ____
2. ____
3. ____
4. ____
5. ____

I authorize **Léger Physical Therapy** to release pertinent clinical and account information to the following **Health Care Providers**:

1. ____
2. ____
3. ____
4. ____

PATIENT NAME (printed):____

SIGNATUREOF RESPONSIBLE PARTY:____

Relationship to Patient:____

PRINT NAME:________________________________DATE:__________________
(If other than Patient)

WITNESS:____

Revised 12-1-19

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Patient Intake Information

______________________________	______________	__________________
Patient Name	**Current Age**	**Date of Evaluation**

Please complete the following information. This will assist us in designing the most effective and efficient individualized program for you. Every Item is significant and important. Thank you.

Who recommended you to this office____

Diagnosis/Main Problem:____

Surgery Performed: ☐ Yes ☐ No____

Prior Hospitalization: ☐ Yes ☐ No____

Please list below the main complaints/challenges you have in order of their importance:

1. ____
2. ____
3. ____
4. ____

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PAIN:

Location(s) of Current pain:____

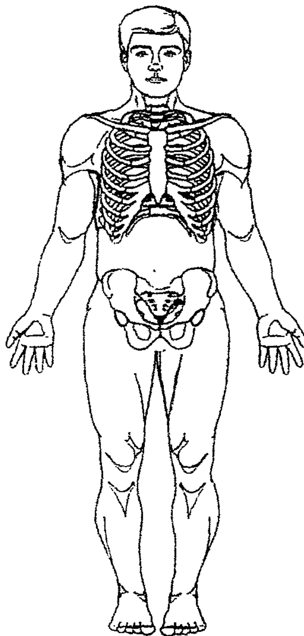
What makes your pain worse____

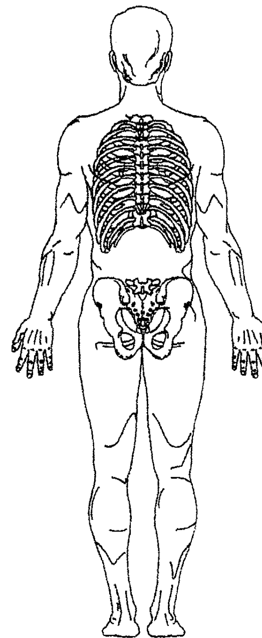
What makes your pain better?____

Pain Diagram:

Please shade in all areas of pain.

Front **Back**





P: 470-539-4485 F: 470-539-4561

Medical History:

Previous History of Similar Injury: ☐ Yes ☐ No

Are you a current patient of Home Health Care: ☐ Yes ☐ No

History of Falls: ☐ Yes ☐ No

Diagnostic Test/Imaging (X-ray, MRI, CT, etc): ☐ Yes ☐ No ____________________

Unexplained Weight Loss ☐ Yes ☐ No

Please Check all that apply:

☐ Osteoarthritis

☐ Cardiovascular Disease

☐ Diabetes

☐ Allergies

☐Surgical History ____

☐Previous Physical Therapy____

☐History of Cancer____

☐ Current Infection

☐ Immunosuppression

☐ Fracture

☐ Cauda Equina Syndrome

☐ Other ____

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Current Medications:

Please List any prescribed medication, over the counter medication, and/or supplements you are taking:

Name of Medication/Supplement	Dosage	How long have you taken medication/supplement?

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Are you seeing any other doctors or health care professionals now for any reason? ☐ Yes ☐ No

Practitioner's Name	Type of Practitioner:	Phone Number or Address:
______________________	______________________	______________________________
______________________	______________________	______________________________
______________________	______________________	______________________________

Do you want us to send out an evaluation note to these practitioners? ☐ Yes ☐ No

Physical Therapy Goals:

1.____

2.____

3.____

4.____

5.____