Snyder Physical Therapy & Sports Rehabilitation

2845 South 70th Street, Lincoln, NE 68506 P# 402/489-1999 F# 402/489-4153

General Information

Patient Name: _____ Gender: *M / F* DOB: _____ SSN: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone #: (H) _____(C) _____ Text Communication Approved: Y N

Email: _____Marital Status:_____

Employer: _____Work phone#: _____

Emergency Contact: _____ Phone #: _____

How did you hear about us? □ Previous Patient □ Dr. Referral □ Google/Bing/Yahoo □ White/Yellow Pages

□ Family/Friend: (Name Optional) _____

Insurance Information (A copy of insurance card(s) and drivers license will be taken)

Primary Insurance Name: _____ Policy Holder: _____ DOB: _____

Secondary Insurance Name: _____ Policy Holder: _____ DOB: _____

Guarantor Contact Information (For patients who have bills sent to parents)

Guarantor Name: _____SSN:_____Relationship:_____

Billing Address: _____City: _____ State: _____ Zip: _____

Mother's Phone #: _____ Father's Phone #: _____

Mother's Employer: _____ Father's Employer: _____

Employer's Phone #: _____ Employer's Phone #: _____

Current Condition(s)/Chief Complaint(s)

Injury Area: _____

Referring Physician: _____

Date of Injury: _____

Type of injury: Sports / Employment / Vehicle / Other

List date of last procedure related to injury:

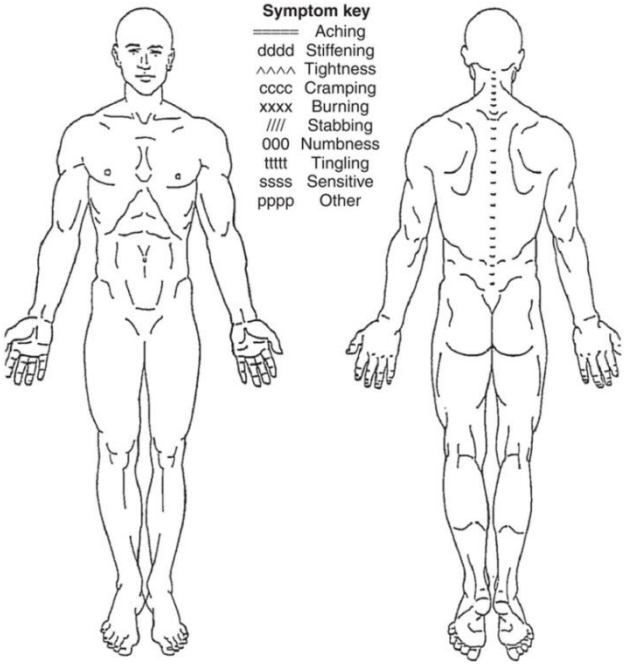
Surgery: _____ Location: _____

MRI: _____Location: _____

X-Ray: _____ Location: _____

How did the injury occur: _____

_____



Please rate the intensity of your pain, for your current condition, on a scale of 0 to 10, 0 being no pain and 10 being the worst pain possible

Today: _____

Best: _____

Worst: _____

Activities that cause pain: _____

_____

_____

Patient Health History

Height: _____ Weight: _____ Age: _____ Family Physician: _____

Please mark if you have ever had:

- ❑ Arthritis
- ❑ Osteoporosis
- ❑ Blood Disorders
- ❑ Multiple Sclerosis
- ❑ Cancer
- ❑ Parkinson's disease
- ❑ Seizures/epilepsy
- ❑ Thyroid problems
- ❑ Heart Problems
- ❑ Lung Problems
- ❑ High blood pressure
- ❑ Infectious disease
- ❑ Kidney problems
- ❑ Cortisone drug
- ❑ Depression
- ❑ Muscular dystrophy
- ❑ Stroke
- ❑ Head Injury
- ❑ Allergies
- ❑ Circulation problems
- ❑ Diabetes
- ❑ Ulcer
- ❑ Hepatitis
- ❑ Other: _____

List of allergies: _____

Are you pregnant or think you may be pregnant? Yes / No Do you have a pacemaker? Yes / No

Do you smoke? Yes / No if "Yes" how many packs per day? _____

Surgeries, Fractures, Major illnesses/injuries	Year

Medications	Dosages

_____ _____ _____

Signature of Patient (Parent or Guardian under 19 years old) Date Relationship

Patient Financial Policy

Please initial next to one of the following payment agreements

_____ **Health Insurance Carriers:**
I am covered by an insurance plan and hereby authorize all payments go directly to Snyder Physical Therapy, LLC. I agree to pay the amount my insurance plan indicates I am responsible for at the time of service. I understand it is my responsibility, as the policy holder, to understand the limitations, exclusions, and covered benefits of my policy. I agree to provide written authorization prior to my receiving treatment if an authorization is required by my insurance plan. Please contact your plan administrator or the insurance company's customer service department for questions regarding your coverage.

_____ **Medicare:** I am a Medicare recipient, and understand Snyder Physical Therapy, LLC accepts assignment of Medicare claims. The Medicare Physical Therapy/ SLP cap for 2023 is $2,230 per year. I understand that Snyder Physical Therapy, LLC will file my claims for me to both my Medicare and secondary insurance.

_____ **Medicaid:** I am covered by Medicaid and verify that my coverage is active. If my eligibility status changes I will let Snyder Physical Therapy, LLC know. I understand that if I am seen without coverage I am responsible for the charges incurred. Should my Medicaid plan have a co-pay or deductible requirement, I agree to make payment at the time of service.

_____ **No Insurance:** I have no assignable third party coverage and Snyder Physical Therapy, LLC will not file an insurance claim for my services. We ask that you remit payment within ten days of receiving your monthly statement. We are happy to accept payments by cash, check, or credit card. If your account reaches 90 days past due and you have not contacted us to make a payment arrangement, your account may be turned over to our collection agency.

_____ **Law Suit/Liability:** Our policy is to file liability claims on behalf of our injured patients. However, if denial is received or if your claim is not settled within six months, we will ask that you begin to make regular monthly payments. Failure to make these payments may result in your account being turned over to a collection agency. We can also submit to your health insurance for payment at your request as one as the information is provided to us. We will work with you to establish a reasonable monthly payment plan to accommodate your needs. If an attorney is involved, we will file a lien with them, but this is no way releases your responsibility in making required monthly payments. ****Fill out Liability Form**

_____ **Workers Compensation:** I have a work related injury. Snyder Physical Therapy, LLC will bill my employer for the services rendered, and in the event of a dispute with my employer about the work-relatedness of my injury, I accept full responsibility for payment of my account, I will provide a copy of my person health insurance card to Snyder Physical Therapy, LLC.
****Fill out WC Form**

Please initial all four lines below:

_____ **Consent to Treat:** I understand that I am giving permission for evaluation and treatment by Snyder Physical Therapy, LLC and that I have the right to refuse any procedures after having the risks and benefits explained to me.

_____ **Assignment of Benefits:** I herby authorize Snyder Physical Therapy, LLC to furnish information to the above-named insurance carrier(s) concerning my treatment and hereby assign to the therapist(s) all payments for services rendered. I understand that I am responsible for all charges, even those not paid by my insurance. I also consent to the release of my health care records to be reviewed by my insurance company or any necessary audits within Snyder Physical Therapy, LLC.

_____ **HIPAA Notice of Privacy Practice:** I acknowledge that Snyder Physical Therapy, LLC has offered or supplied me with a copy of their HIPAA Notice or Privacy Practice regarding policies and procedures concerning my Protected Health Information (PHI). I agree to release authorization to Snyder Physical Therapy, LLC to use my PHI as deemed necessary for treatment, billing and the purposes mentioned in the notice.

_____ **Monthly Statement:** I acknowledge that a Patient Account Statement will be sent at the end of the month from Snyder Physical Therapy, LLC @ 2810 W 30th Street, Suite #2, Kearney, NE 68845. If you have any questions regarding your statement feel free to call the clinic in Lincoln at (402)489-1999 or Kearney at (308)237-7388.

_____ _____ _____
Signature of Patient (Parent or Guardian under 19 years old) Date Relationship

SNYDER PHYSICAL THERAPY
& Sports Rehabilitation

HIPAA Agreement

By signing this form I give permission to Snyder Physical Therapy, LLC to discuss my medical condition with the following people:

Spouse: _____

Parents: _____

Children: _____

Caregivers: _____

Guardian: _____

Other: _____

Lawyer/Attorney: _____

_____
Name of Patient

_____ _____
Signature of Patient Date

_____ _____
Guardian Signature (under 19 years old) Relationship to Patient