RI Limb Prosthetics, Orthotics And Physical Therapy

Patient Information Date: _____

Patient name: _____ Address: _____

Home phone: _____ cell phone: _____ Work phone: _____ E-mail: _____

Date of birth: _____ SSN: _____

Emergency Contact name and phone number: _____

Employer Company name: _____ Work phone: _____
Company address: _____

Reason for Treatment

Problem: _____

Referring or treating doctor: _____ Primary care physician: _____

Who referred you to our facility (doctor, friend, family member name) : _____

Insurance provide your card for photocopy and you can skip these sections

Primary insurance carrier: _____ ID number: _____ Group number: _____

Subscriber information: (name DOB, Relationship) _____

Secondary insurance carrier: _____ ID number: _____ Group number: _____

Subscriber information (name, DOB, Relationship) _____

Workman's Compensation Coverage

Date of injury: _____ Employer at the time of injury: _____
Claim number _____ Adjuster: _____ Phone number: _____

Motor Vehicle Accident or **Other Type of personal injury litigation** (i.e., slip and fall)

Claim number: _____

Insurance carrier: _____ Insurance policy number: _____

Adjuster's name: _____ Adjuster's phone number: _____

Date of accident : _____ State in which the accident occurred _____

Attorney Information: Please complete if you have an attorney handling your injury case

Attorney's name: _____ Phone number: _____

Address: _____

Patient or Guardian Agreement

I authorize release of information requested by my insurance plan for payment
I understand I am responsible for any balance due and have reviewed RI Limb Prosthetics, Orthotics And Physical Therapy's financial policy
I agree to comply with the posted policies of RI Limb Prosthetics, Orthotics And Physical Therapy I authorize evaluation and treatment by
RI Limb Prosthetics, Orthotics And Physical Therapy
I have been offered and received / declined a copy of the notice of privacy practices from RI Limb Prosthetics, Orthotics And Physical Therapy

Signature of the patient or Guardian _____ Date: _____

MEDICAL HISTORY

Name:

Arthritis ☐Rheumatoid ☐ Osteoarthritis

☐Fibromyalgia
☐Diabetes or problems with blood sugar
Controlled ☐Yes ☐No
☐ Diet ☐Medication ☐Insulin
☐Heart problems/Heart Attack
☐Liver problems
☐Metal implants/ joint replacements
☐Neurological problems (such as stroke, Parkinson's disease, multiple sclerosis, muscular dystrophy, polio)
☐Thyroid problems: ☐Hypo ☐Hyper ☐other:_____

☐ Broken Bones/Fracture

☐Cancer: Type: _____
☐Head Injury
☐High Blood Pressure
Controlled by Medication ☐Yes ☐No
☐Kidney Problems
☐Lung problems (asthma, COPD, Emphysema, shortness of breath)
☐Osteoporosis
☐Sensitivity to latex rubber
☐other not listed above: _____

MEN:
☐Prostate disease Other: _____

WOMEN:
☐Gynecological Issues / Pregnant? ☐Y ☐ N

MEDICATIONS (if you have a list we can copy and enter it into your chart)
Prescription medications: _____

_____

Over the counter medications: ☐Ibuprofen/Naproxen ☐Aspirin/Tylenol ☐Herbal supplements ☐Vitamins/Other
Please list any OTC not noted above _____

Reason for today's visit

Date symptoms began: _____
Cause of symptoms if known: _____
Describe your main complaint: _____

_____

_____

Surgery related to this problem: ☐no ☐yes Type of surgery _____ Date of surgery _____

Any special testing ☐MRI ☐x-ray ☐EMG ☐CT scan ☐ultrasound ☐EMG/nerve conduction ☐other: _____

This problem affects your ability to:
☐walk ☐ climb stairs ☐bend/lift ☐work ☐sleep ☐ exercise☐ sit ☐stand ☐overhead activities ☐dress ☐reach ☐drive ☐ grasping manipulating objects ☐use the computer ☐other: _____

Current symptoms or complaints

Where is your pain: _____

Is it ☐sharp ☐achy ☐stabbing ☐tingling ☐numb ☐burning ☐constant ☐intermittent?

How intense is your pain? **No pain** ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 **would go to the hospital**

What makes your pain better? ☐sitting ☐standing ☐walking ☐lying down ☐stretching ☐exercising ☐Other: _____

What makes your pain worse? ☐sitting ☐standing ☐walking ☐lying down ☐stretching ☐exercising ☐Other: _____

Previous treatment? ☐PT ☐chiropractic ☐injections ☐massage ☐other:_____
Results: ☐Resolved ☐Partially resolved ☐not resolved ☐ worsened

Have you received any: ☐ home care ☐nursing home care ☐hospitalization over the past year?

Signature: _____ Date: _____

Reviewing therapist signature: _____

RI Limb Prosthetics, Orthotics And Physical Therapy

18 Fifth Ave | EAST GREENWICH RI, 02818 | (401) 884-9541

Financial Policy

Thank you for choosing RI Limb Prosthetics, Orthotics And Physical Therapy. Our primary mission is to deliver the best and most comprehensive care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa or MasterCard –see credit card authorization. If you chose to pay by check or cash we still require a credit card on file.
- Convenient Monthly Payment Plans[1] from CareCredit
  - Allow you to pay over time
  - No annual fees or pre-payment penalties

Please note:

RI Limb Prosthetics, Orthotics And Physical Therapy requires payment at the time of your treatment.[2]

If you have a deductible that has not been met we will collect $75 for each session until your deductible has been met. We will bill the insurance carrier so you will receive credit toward your deductible.

If you have co payments and or co insurance due they will also be collected at the time of service based on your individual policy. Your co-insurance will be determined based on the treatments you usually receive.

Should there be any overpayment on co-insurance or deductibles you will receive a refund within 45 days of final insurance processing of your claim.

If you require more time to pay larger amounts you may apply for the CareCredit Card to finance larger deductibles. Please inquire for more details regarding finance options or apply on line at carecredit.com

For patients with insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[3]

A fee of $25 is charged for patients who miss or cancel more than 1 time without 24-hour notice.

RI Limb Company Physical Therapy charges $25 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the treatment and care you want and need.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

[1]Subject to credit approval.

[2]If you do not pay any amount which is due to RI Limb Prosthetics, Orthotics And Physical Therapy within 30 days of receipt of statement you will be in default of this agreement and responsible for any and all fees related to collections of these funds. [2]However, if we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

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Credit Card On File Authorization

With the ever changing healthcare reimbursement, deductibles and other patient responsibilities, RI Limb Prosthetics, Orthotics And Physical Therapy is no longer able to carry balances on theses charges. We have provided the following options to meet the obligations related to your portion of treatment costs. We will require your payments to be paid on the date of service. **We will secure your credit card information and make charges to your account to cover any outstanding balances not paid by your insurance company**. You may select below how you would like to have these charges applied if you chose to pay your balance with card on an ongoing basis.

I _____authorized RI Limb Prosthetics, Orthotics And Physical Therapy to keep my credit card on file and charge my credit card as follows:

_____ for copayment/estimated co insurance **or** my deductible at **each session** (for deductible the initial visit cost is $100 and subsequent visits are $75). We will bill your insurance company so you will receive credit towards your deductible

_____ for co-payments, co insurance, deductible or other medically related service charges **when the insurance statements come in.**

_____ on a **monthly basis for the balance due** on my physical therapy services including co insurance, deductible or other medically related service charges

Pleased complete the information below:

Billing Address: _____ Phone: _____

City, State, Zip _____ E-Mail: _____

Account Type: Visa MasterCard

Cardholder Name _____

Account Number _____

Expiration Date _____

CVV (3 digit number on back of Visa/MC) _____

SIGNATURE: _____ DATE:_____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the business in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. This payment authorization is for the type of bill indicated above. I certify that I am an authorized user of this credit card and that I will not dispute the scheduled payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form.