MasterCare
PHYSICAL THERAPY

Patient Information

Patient Information:

Last Name: _____ First Name: _____ Date of Birth: _____

Permanent Address: _____

City: _____ State: _____ Zip: _____

Seasonal Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell phone: _____ Work Phone: _____

Email address: _____

Referring MD: _____

Chief Complaint for visit: _____

Date of injury/accident _____ Auto Worker's Comp

Are you currently receiving care from a home health agency? Yes / No

Emergency Contact Information:

Name: _____ Relationship: _____

Phone: _____

Primary Insurance Information:

Carrier: _____ Phone: _____

Member ID: _____ Group #: _____

Policyholder: _____

Secondary Insurance Information:

Carrier: _____ Phone: _____

Member ID: _____ Group #: _____

Policyholder: _____

Guarantor/Financially Responsible Party: (Only complete this section if guarantor is NOT the patient.)

Last Name: _____ First Name: _____ DOB: _____

Initial Completion of this form: By signing below, I certify all information is true and correct to the best of my knowledge.

Signature: _____ Date: _____

Please sign below when directed by front office only.
By signing below, I certify all information is true and correct to the best of my knowledge.

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

Patient Consent

Patient Name: _____ Date: _____

Consent for Treatment

I (patient's name) _____ hereby authorize MasterCare Physical Therapy, Inc. to provide treatment which the referring physician determines necessary and/or advisable. I consent to medical treatment as is deemed necessary or advisable by the physical therapist. I authorize MasterCare to obtain and acquire any information that would be beneficial in connection with my therapy service, which may include X-Rays, CT Scans, and MRI reports, along with physician's documentation. It is further understood that this clinic is authorized to carry out all instructions of the patient's physician and that the clinic is hereby relieved of all liability occurring from the performance of the physician's instructions.

Consent to Release Information

The practice may use my Protected Health Information (PHI) to treat me or disclose my PHI to other healthcare providers, such as my referring physician or my primary care physician, for purposes related to my treatment. I consent that the practice may release any medical information that has been obtained during my course of treatment to any hospital, physician or insurance company to answer any inquiries per Federal and State regulations. The practice may use or disclose my PHI internally or disclose my PHI to other health care providers and entities as necessary to operate their business. The practice may use and disclose my PHI to contact me for appointment reminders and to inform me of potential treatment options or alternatives. The practice may use and disclose my PHI to advise a friend or family member that is involved in my care or who assists in taking care of me. My PHI may also be used and disclosed when Federal, State, or local law requires. The practice may share my PHI with third-party "Business Associates" that perform activities on their behalf such as billing and/or software maintenance.

Written Acknowledgement of Notice of Privacy Practices

I have the right to review the Notice of Privacy Practices prior to signing this consent. MasterCare Physical Therapy, Inc. reserves the right to revise Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to MasterCare Physical Therapy, Inc. Privacy Officer at 5560 Bee Ridge Road, Suite D13, Sarasota, FL 34233.

Consent for 3rd Party Release

Authorization for family, friends, or advisors to receive information about your medical condition or the status of your bill.
I, (print name) _____, authorize the following individual(s) to receive written and/or oral communications about my medical condition, care, appointments and the status of my bill.

Name:_____Relationship: _____Phone: _____

Name:_____Relationship: _____Phone: _____

I give MasterCare Physical Therapy, Inc. permission to leave appointment reminders on my ____ voicemail, ____ email.

I give MasterCare Physical Therapy, Inc. permission to leave medical and billing information on my ____ voicemail, ____ email.

Signature: _____Today's Date:_____

I certify that I have read the above information. My signature certifies my understanding of and agreement with the above consents.

Signature: _____Today's Date:_____

Signature: _____Today's Date:_____

Signature: _____Today's Date:_____

If signed by legal representative- Name & relationship: _____

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Office and Financial Policy

Patient Name: _____ Date: _____

We are dedicated to you, and our goal is to give you the best care available. We know that dealing with the financial side of your care may be confusing and stressful; therefore, we are providing you with information to clarify your financial responsibility.

- **Consent Form** must be signed and updated yearly. This form allows us to submit medical claims for services provided to your insurance company, as well as appeal improperly paid claims. *Refusal to sign this form will result in you being considered a self-pay. You will then be responsible for our entire billed amounts.*
- Your personal information (address, phone number, etc.) must be updated whenever there is a change, as well as your insurance information. You will be asked to produce a picture ID, as well as proof of insurance. We will verify coverage prior to services being provided. We rely on the information you provide in order to bill third parties for your medical services. **Balances that are not paid due to errors or omissions in the information you provide may result in the entire balance becoming your responsibility.** Please be sure to report all potential third-party sources of payment (auto insurance, worker's compensation, supplemental, secondary, etc.).
- Most insurance policies require patient co-pay for office services. *Payment co-payment is required at time of service.*
- If you are a self-pay patient, payment in full is expected at the time of service.
- We accept cash, check, and all major credit cards.
- MasterCare is contracted with many insurance networks. If you are unsure if we participate with your insurance, please ask to speak with someone in our financial department.
- MasterCare may not be a participating provider with your insurance company. Your insurance company may send payment for our services directly to you. By signing our **Consent Form,** you agree that it is your financial responsibility to forward any payment received to this office. Failure to send us payments you have received from your insurance company for services provided by MasterCare may result in your account being turned over to collections.

I hereby authorize direct remittance of payment of insurance benefits including Medicare, if applicable, to the practice for all covered medical services rendered. I understand and agree this assignment of benefits will have continuing effect for as long as I am being treated by the practice, and will constitute a continuing authorization, maintained on file with the practice, for all subsequent and continuing treatment, services, and/or supplies provided to me by the practice. The practice may use and disclose my Protected Health Information in order to directly bill and collect payment for services and items I receive, to obtain payment from me or from third parties that may be responsible for such costs, or to assist other health care providers in their billing and collections. I accept legal responsibility for charges that my insurance company does not cover, and I will pay for these at the time of my visit unless prior arrangements have been made. I am also responsible for all legal fees, collection fees, and interest incurred in the event my account becomes delinquent. In the event collection efforts are necessary, I agree to pay an additional 33.3% of the outstanding balance for the standard collection cost incurred. I understand that the practice may not be a participating provider with my insurance company. Should I receive payment directly from the insurance company, I agree to forward the check and "Explanation of Benefits" to the practice within 10 days of receipt. If I fail to provide this information, I understand that I will be held legally responsible for payment in full for all services or equipment that has been provided.

Signature: _____Today's Date:_____

I certify that I have read the above information. My signature certifies my understanding of and agreement with the above consents.

Signature: _____Today's Date:_____

Signature: _____Today's Date:_____

Signature: _____Today's Date:_____

If signed by legal representative- Name & relationship: _____

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Past Medical History

Patient Name: _____ Date of Birth: _____

- ☐ Balance difficulties
- ☐ Cancer
- ☐ Chest pains
- ☐ Diabetes
- ☐ Dizziness/fainting
- ☐ Epilepsy
- ☐ Headaches
- ☐ Heart attack
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Hypoglycemia
- ☐ Infectious disease
- ☐ Kidney problems
- ☐ Low blood pressure
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Pacemaker or defibrillator
- ☐ Rheumatoid arthritis
- ☐ Seizures
- ☐ Shortness of breath/difficulty breathing
- ☐ Stroke

Allergies: _____

_____

Other Health Issues (please explain): _____

_____

Surgeries: _____

_____

In case of emergency, which hospital would you prefer to be taken to?

_____

Are you taking any medication? Yes No

If yes, please list or attach medications: _____

_____

_____

By signing below, I certify all information is true and correct to the best of my knowledge.

Signature: _____Today's Date:_____

Signature: _____Today's Date:_____

Signature: _____Today's Date:_____