East Athens Physical Therapy

WORKERS COMPENSATION

Today's Date _____ Date of Injury _____

Name _____
First MI Last

Address _____ _____
Street Apt # PO Box

_____
City State Zip

Home Phone ___-___-_____ Work Phone___-___-_____ Cell Phone___-___-_____

SS# ___-___-_____ Male or Female Marital Status M S D W

Date of Birth: _____ E-Mail: _____

Emergency Contact: _____ Phone: _____

How did you hear about us? _____

Employer Information **Occupation**_____

Employer _____

Address _____ _____
Street Apt # PO Box

_____
City State Zip

Physician Information

Primary Care Physician Name _____

Address _____
Street City ST Zip

Phone ___-___-_____ Fax ___-___-_____

Referring Physician Name _____

Address _____
Street City ST Zip

Phone ___-___-_____ Fax ___-___-_____

Date of your return visit? _____

Have you had physical therapy for this claim before? ___ No ___ Yes If yes, when?_____

Worker Compensation Claim Information

Claim Number_____ Insured Name _____

Have you completed and returned a Personal Injury Protection application to insurance company? _____

Insurance Company Name _____

Address _____
Street City ST Zip

Phone ___-___-_____ Claims Adjuster _____

ATTORNEY: Name & telephone number _____

Attorney address_____
Street City State Zip

East Athens Physical Therapy

Health Insurance Information

Primary Insured Name _____ Insured Date of Birth _____

Relationship to insured _____ Insured Phone # _____

Insured Address if Different from Patient:

Address _____
Street City ST Zip

Health Insurance Co Name _____ Ins Phone #_____

Address _____
Street City ST Zip

Group Number_____ ID Number_____

Contact Name _____

CONSENT TO TREATMENT

I hereby authorize the professional staff at **East Athens Physical Therapy** to examine and treat me with physical therapy for the injury for which I have been referred.

X _____ X _____
Patient Signature Date

X _____ _____
Patient Printed Name Staff Witness Signature

_____ _____
Parent or Guardian Signature Date

_____ _____
Parent or Guardian Printed Name Staff Witness Signature

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO HEALTH PROVIDER

Insurance Company/Companies Name(s) _____

I hereby instruct the above named insurance company/companies to pay by check made out to and mailed directly to: East Athens Physical Therapy for professional or medical expenses allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment or as required by my insurance policy. I understand that **East Athens Physical Therapy** complies with HIPPA and will protect my Protected Health Information (PHI) and will use it as allowable by law in the treatment, billing and collection pertaining to my care until my case is closed and full payment is received. I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney for the purpose of securing payment under this policy of insurance or to any Medical Provider associated with my case to effectively treat me. The authorization is in effect until 90 days from the date the last bill is collected.

HIPPA REGULATIONS A photocopy of this Assignment shall be considered effective and valid as the original.
I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney for the purpose of securing payment under this policy of insurance under the HIPPA guidelines.

X _____ X _____
Patient Name (Printed) Date **Patient Signature**

_____ _____
Parent or Guardian (Printed) Relationship **Parent or Guardian Signature**

Witness _____ Date_____

Medical Information Release Form

(HIPAA Release Form)

Name:_____ **Date of Birth:**_____/_____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse _____

[ ] Child(ren) _____

[ ] Other _____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (day)_____ between (time) _____

I authorize East Athens Physical Therapy and their respective agents to contact me at the current or any future number that I provide for my cellular phone or other wireless device using automated telephone dialing equipment of artificial or pre-recorded voice or text messages.

Signed: _____ Date: _____/_____/_____

Witness: _____ Date: _____/_____/_____

East Athens Physical Therapy (EAPT) - MEDICAL HISTORY

Patient Name_____ Next Doctor's Appointment_____

Type of Surgery/Injury & Date/Onset_____

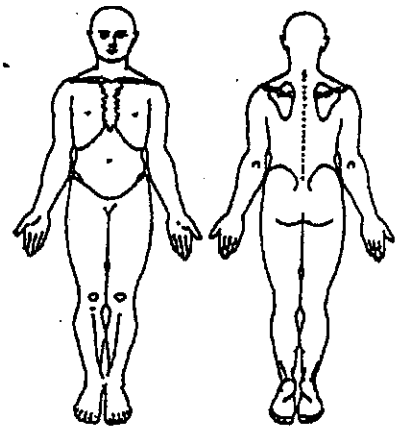
Describe previous treatment for this condition_____

_____

*(Required by 2019 insurance mandate) Height_____Weight_____

For any questions regarding nutrition please contact:
Piedmont's Outpatient Nutrition Services at 706-475-1000 option 2

*(Required by 2019 insurance mandate)
Have you fallen within the last year? _____ If yes how many times _____



Please mark the area(s) of concern

Have you had any imaging performed:

- ☐ X-Ray
- ☐ MRI
- ☐ CT Scan
- ☐ Doppler
- ☐ Ultrasound

Have you recently noted:

- ☐ Weight Loss / Gain
- ☐ Weakness
- ☐ Pregnant / IUD
- ☐ Pain at Night
- ☐ Nausea / Vomiting
- ☐ Fever / Chills / Sweats
- ☐ Headaches
- ☐ Cramps in Legs When Walking
- ☐ Fatigue
- ☐ Numbness / Tingling
- ☐ Change in Vision / Hearing
- ☐ Insomnia

Do you have now or have you ever had any of the following:

- ☐ Surgeries
- ☐ Sprains / Strains
- ☐ Heart Problems
- ☐ Circulation Problems / Clots
- ☐ Easy Bruising / Bleeding
- ☐ Indigestions / Heartburn
- ☐ Rheumatoid Arthritis
- ☐ Loss of Consciousness
- ☐ Diabetes
- ☐ Cancer
- ☐ Asthma / Breathing Problems
- ☐ Leg / Ankle Swelling
- ☐ Fainting
- ☐ Fractures
- ☐ Blood Pressure Problems
- ☐ Motor Vehicle Accident
- ☐ Lung Disease
- ☐ Urinary Problems / Infections
- ☐ Allergies / Skin Sensitivity
- ☐ Any previous injury that may affect current care _____

Explain and give approximate dates for any items indicated above _____

_____

*(Required by 2019 insurance mandate) Are you currently taking medications? Yes / No

*(Required by 2019 insurance mandate) Name and dosage of Medication _____

_____

_____

_____

_____

_____

Type of Pain: Sharp / Burning / Aching / Tingling / Numbness / Other _____

*(Required by 2019 insurance mandate)
Rate your pain At worst: 1 2 3 4 5 6 7 8 9 10 At best: 1 2 3 4 5 6 7 8 9 10 Current 1 2 3 4 5 6 7 8 9 10

_____ _____

Patient or Personal Representative Signature **Date**