therapydia

Physical Therapy - Human Performance

Group NPI: 1740611359
Tax ID: 27-4427322
Provider NPI: Jonantha Burke - 1922339399

Appt. Date:________________________________

PATIENT INFORMATION:

Name:______________________________ Date of Birth:______________________________

Address:______________________________ Home Phone:______________________________

City, State, Zip: ______________________________ Cell Phone:______________________________

Email:______________________________

Referring Physician:______________________________ Diagnosis:______________________________

Primary Physician:______________________________ Date of Surgery/Injury:______________________________

My injuries occurred as a result of someone other than myself (circle one): YES or NO

Please describe details of injury/onset:____

____

MUST BE COMPLETED:

My injuries occurred as a result of someone other than myself (circle one): YES or NO

If Yes, please circle one: Work Accident Auto Accident Other

Please describe details of accident:____

Who do you believe is responsible for your injury?____

Name of Attorney, if any:____

Are you currently under Home Health Care (VNA)(circle one)?: YES or NO

This calendar year have you had any other physical, occupational or speech therapy?: YES or NO

Employment Status (circle one): Fulltime Part time Retired Fulltime Student

Minor or Student:

Parent/Guardian Name:______________________________ Relationship:______________________________

Address (if different from above):____

____

Primary Insurance:______________________________ ID#:______________________________

Name of Insured:______________________________ Group#:______________________________

Date of Birth:______________________________ Relationship to patient:______________________________

Secondary Insurance:______________________________ ID#:______________________________

Name of Insured:______________________________ Group#:______________________________

Date of Birth:______________________________ Relationship to patient:______________________________

It is my responsibility to know and understand my insurance benefits and obligations. ____________(Initial)

Signature acknowledges all information provide to be correct: ______________________________ **Date:** __________

How did you hear about us?

Please Circle One: Prescribing physician____ Self ____ Other____

If self-referred:

____Online: Clinic Website/ Facebook / Therapydia / Other Website: ____________________

(Please circle one)

____ Offline: Follow-up Visit / Clinic Storefront / Advertisement /Event: ____________________

OFFICE USE- INS. VERIFICATION____

____

____

PAYMENT POLICY

PAYMENT DUE AT TIME OF SERVICE: Therapydia NOLA is in-network with Medicare, BCBSLA, Humana, United Healthcare.

ASSIGNMENT OF BENEFITS: I, ________________________, understand and authorize the release of medical information to file health insurance claims for me by Therapydia. I authorize Therapydia to bill my insurance company directly for the covered portion of the charges. I also authorize my insurance provider(s) to pay Therapydia directly.________ (Initial)

IN-NETWORK INSURANCE BENETITS: IT IS YOUR RESPONSIBILITY TO KNOW YOUR BENEFIT INFORMATION AND YOU ARE ULTIMATELY FINANCIALLY RESPONSIBLE FOR ALL SERVERICES RENDERED TO YOU. You agree to pay your deductible, co-insurance or co-pay, and any charges not reimbursed by your insurance carrier. Collection of your deductible, co-insurance, or co-pay will be collected on the date of service. Please note that what we collect in the office may only be a portion of your balance. Actual patient responsibility can only be determined once your insurance company has processed a claim. If you have further financial obligation than what we collect/collected in the office, you will receive a statement from our billing company to be paid in full within 30 days. If your account is deferred to a collection agency, you agree to pay all collection costs incurred.

OUT-OF-NETWORK INSURANCE BENEFITS: If we are out-of-network with your insurance provider, you are responsible for payment AT THE TIME OF SERVICE. We will submit a super-bill to your insurance provider on your behalf. For clients without insurance or who do not wish to submit a super-bill, Therapydia NOLA offers a cash/self-pay rate.

I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL INFORMATION. I UNDERSTAND MY RESPONSIBILITY FOR PAYMENT OF MY ACCOUNT.

Patient Signature:____

Printed Name:____

Date:____

Parent/Guardian Signature(if applicable):________________________

Printed Name:____

Date:____

2701 Airline Drive, Metairie, LA 70001
504.324.8345

CANCELLATION/NO-SHOW POLICY

Cancellations and No-Shows: Appointments cancelled with less than 24-hours notice will be subject to a fee of $75.00. This fee will either be charged to a credit card on file, collected at your next scheduled visit, or billed by our billing department. Invoices that are not paid, are subject to collection deferment.

If we are able to fill your appointment time, you will not be charged. However, if we are unable to fill the time, you are subject to the $75.00 charge.

No-Shows, if you do not show for your appointment, and do not give notice, you are automatically subject to the $75.00 charge.

I have read and understand the Cancellation/No-Show Policy of Therapydia NOLA,

Patient/Client Signature:______________________________

Printed Name:______________________________

Date:______________________________

Parent/Guardian Signature(if applicable):______________________________

Printed Name:______________________________

Date:______________________________

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Physical Therapy Pre-Prostate Surgery Questionaire:

Patient name: Date :

Urinary Incontinence / Voiding/ urgency/ leakage:

Any urine leakage? How often? How much?

Caused by:

Is leakage associated to strong urge to urinate?

Any previous treatment for leakage?

Do you wear any protection?
How often do you go to the toilet to urinate?

Do you wake in the night to urinate? How often

Can you delay once you have the urge?

Any trouble initiating urination:

Do you dribble after you finish urinating?

Do you strain to empty the bladder?

Any pain with urination?

Any recent bladder infections?

Bowel function/frequency / urgency/ constipation / leakage

How are your bowels?

Are you regular?

Are you constipated? What do you use to relieve?

Do you leak any stool?

Name: Date:

Fluid / food intake:

Describe what you usually drink through the day- glasses of water ____ diet drinks _____ sugared soft drinks _____ tea _____ decaf coffee _____ regular coffee _____ alcohol _____ __ Other____________

Are you a good fruit and vegetable eater?

Do you eat fibre?

Pelvic Pain/ Sexual function:

Are you sexually active?

Can you complete coitus?

Is there any associated pain? Describe?

Medical conditions:

Heart	Lungs
Smoker	Diabetes
Epilepsy/seizures	Hypothyroid/ Hyperthyroid
Back pain	Surgery

Other:

Functional limitations:

Is there any limitation to your daily activities because of your prostate?

Describe your general level of activity:

Home life/ work life:

Occupation:

Who will be at home to help you?

CONSENT FOR TREATMENT

I, hereby agree and give my consent for Therapydia NOLA to provide physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition. This consent is intended as a waiver of liability for such treatment excepting acts of negligence.

Patient/Client Signature:______________________________ Date:________________

PARENTAL CONSENT FOR TREATMENT: As parent and/or legal guardian of, ______________________________, I authorize Therapydia NOLA to treat while I am not present.

Parent/Guardian Signature:____________________________ Date:________________

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Notice of Privacy Practices for Protected Health Information
Health Insurance Portability & Accountability Act of 1996 (HIPAA)

Due to increased awareness of the need for more strict guidelines regarding privacy of your protected health information, the Health Insurance Portability & Accountability Act of 1996 (HIPAA) was legislated, effective April 14, 2003. As part of this law, Therapydia Tampa is required to provide you with the option of receiving a copy of this Notice. You are able to receive this Notice either electronically or on paper.

If you decline to receive a paper copy of such Notice at this time, please sign under the Waiver section below, knowing it is available to you in the future should you wish to receive it. If you wish to receive a paper copy of the Notice, please sign under the Acknowledgement section below.

Waiver (Receive HIPAA Electronically)

I, the undersigned, am aware of my right to receive a paper copy of the above Notice and have declined such Notice. I am aware that this Notice is available to me online at Therapydia Tampa website, www.therapydiatampa.com, and I choose to receive such Notice electronically. I understand that it is my responsibility to read and be aware of these rights as outlined in the Notice.

Print Name: ______________________________

Signature: ______________________________

Date Signed: ______________________________

Acknowledgement (Receive HIPAA Paper Copy)

I, the undersigned, acknowledge with my signature that I have received a paper copy of the above-mentioned Notice. I understand that it is my responsibility to read and be aware of these rights as outlined in the Notice.

Print Name: ______________________________

Signature: ______________________________

Date Signed: ______________________________