RCPT
Rec Center Physical Therapy
A Fitness, Sports & Wellness Center

Welcome!

Please Print

Date_____

Section I: Patient Information

Legal Name: _____ Sex: ☐ Male ☐ Female Birth Date: _____ Age: _____

Last First M.I.

Home Address: _____

Street City State Zip

Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed Student: ☐ No ☐ Part-time ☐ Full-time

Home Phone: (____)_____ E-mail Address: _____

Cell Phone: (____)_____ Work Phone: (____)_____

Employment: ☐ Full-time ☐ Part-time ☐ Not Working ☐ Retired Occupation: _____

Employer: _____ *If Rockwell*: ☐ Office ☐ Factory

City: _____ State: _____

Emergency Contact:

Name: _____ Relationship: _____ Phone: (____)_____

Primary Insurance:

Name: _____ Policy #: _____ Group #: _____

Secondary Insurance:

N/A, IF NONE Name: _____ Policy #: _____ Group #: _____

Is patient the Primary Insurance Policyholder? ☐ YES ☐ NO Is patient the Secondary Insurance Policyholder? ☐ N/A ☐ YES ☐ NO

IF YOU ANSWERED "NO" TO EITHER OF THE ABOVE INSURANCE QUESTIONS, COMPLETE SECTION II WITH APPROPRIATE POLICYHOLDER INFORMATION

Section II: Primary or Secondary Insurance Policyholder Information (If different from above)

Legal Name: _____ Sex: Male Female Birth Date: _____ Age: _____

Last First M.I.

Home Address: (If different from patient) _____

Street City State Zip

Phone:

Home: (____)_____ Cell: (____)_____ Work: (____)_____

Occupation: _____ Relationship to Patient: _____ E-mail: _____

Employer: _____ City: _____ State: _____

Section III: Referral Information Self-referred? ☐ YES ☐ NO (If self-referred, please list Family Physician below)

Family Physician: _____ City: _____ State: _____

Was patient referred by family physician? ☐ YES ☐ NO If NO, would you like him/her to receive your initial evaluation? ☐ YES ☐ NO

Referring Physician: _____ City: _____ State: _____

Section IV: Injury/Accident? ☐ YES ☐ NO If NO, ignore this section **If YES, what type?** ☐ Work ☐ Auto ☐ Other_____

State in which accident occurred: ☐ IOWA ☐ OTHER _____

Date of Injury: _____ Lawyer Involved? ☐ YES ☐ NO Name: _____ Phone #: _____

Claim Representative:

Name: _____ Phone #: (_____)_____ Claim #: _____

Refer to Page 2 and HIPAA Booklet; then check Boxes 1 & 2, sign and date

1. ☐ I agree to the statements on the back of page 1.
2. ☐ HIPAA Privacy information was offered to me

check Boxes 3 or 4, as appropriate

3. ☐ As this minor's parent/guardian I authorize treatment
4. ☐ Bill me directly (No insurance information provided)

Signature _____ Date _____ (For Office Use Only) Ins Code _____

Consent for Physical Therapy Evaluation and Treatment

I hereby give my consent and authorize my physical therapist, assistants, and other healthcare professionals who may be involved in my care, to provide care and treatment prescribed by and/or considered necessary by my physician(s)/health care provider(s). I acknowledge that no guarantees have been made to me about the results of treatment.

Initial/Date _____

Authorization for Release of Information

I acknowledge that I have received Rec Center Physical Therapy's Notice of Privacy Practices. I hereby authorize Rec Center Physical Therapy to use and disclose my health information to carry out treatment, obtain payment, and for health care operations. I authorize the release of appointment information left in a voicemail, answering machine, or text message.

Initial/Date _____

Patient Payment Agreement

I request the insurers listed above to pay benefits on my behalf to Rec Center Physical Therapy for any services rendered. I understand that my health insurance company will only pay for services that it determines to be "reasonable and necessary". If my health insurance company determines that a particular service is not reasonable and necessary, or that a particular service is not covered under the plan, my insurer will deny payment for that service and I will be responsible for payment. I also understand that if my health insurance company does make payment for services, I will be responsible for any co-payment, deductible, or coinsurance that applies. In the event my account becomes delinquent and is therefore in default of payment, I accept responsibility for the principal amount owing. By providing us with your wireless/cell phone number, you are hereby granting us and our agents or independent contractors your consent to receive calls on your wireless/cell phone number for billing and debt collection purposes.

Initial/Date _____