



ROBERTS PHYSICAL AND AQUATIC THERAPY

210 Main Street Old Saybrook, CT 06475
PHONE: (860)395-5300/FAX: (860)395-5700

NEW PATIENT INFORMATION

Patient Name: _____
Date of birth: _____ Age: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Phone#: _____
Social Security#: _____
Email Address: _____ Cell Phone#: _____

Emergency Contact: Name _____ Tel#: _____
Relationship: _____

EMPLOYMENT

Patient Employer: _____
Address: _____

Phone: _____
Are you retired? Yes _____ No _____

Is your condition **work-related**? Yes _____ No _____
Is your condition related to an **auto accident**? Yes _____ No _____
If yes, date of injury: _____
Auto insurance company name: _____
Auto insurance phone#: _____
Workers compensation carrier name: _____
Workers compensation carrier phone: _____
Adjuster Name: _____

PRIMARY MEDICAL INSURANCE

Name of policy holder: _____
Policy holder's date of birth: _____
Social Security #: _____
Address: _____



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SECONDARY INSURANCE

Name of policy holder (if different from above): _____

Policy Holder's date of birth: _____

Social Security #: _____

Address: _____

How did you hear about us? Doctor _____ Friend _____ Relative _____ Other _____

PRIMARY PHYSICIAN

Name: _____

Address: _____

Phone#: _____

Fax#: _____

Referring Physician (doctor who sent you here)

Name: _____

Address: _____

Phone#: _____

Fax#: _____

MEDICAL HISTORY

List all medications: _____

Allergies: _____

Please list your primary symptom or complaint: _____

What do you most want to achieve in physical therapy? _____



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CHECK ANY CONDITIONS THAT APPLY TO YOU:

- Heart disease/Cardiac conditions
- Respiratory disease (asthma, emphysema, etc.)
- Diabetes: If yes, do you take insulin? _____
- Seizure disorder: If yes, date of last seizure _____
- Stroke: If yes, date of stroke: _____
- Cancer: If yes, date and type: _____
- Surgery: Date _____ Reason _____
- Infectious disease: Type _____
- Pregnant: If yes, due date _____
- Depression
- Alcohol use: Frequency _____
- Drug use: Frequency _____
- Smoker
- High Cholesterol
- Other/Explain: _____



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FINANCIAL POLICY

Thank you for choosing Roberts Physical and Aquatic Therapy as your health care provider. We are committed to helping you achieve your rehabilitation goals. The following is a statement of our Financial Policy, assignment of benefits and disclosure of records. Prior to any treatment we require that you read and sign.

Health Insurance:

As a courtesy to you, Roberts Physical and Aquatic Therapy will submit insurance forms to your primary insurance carrier. You are responsible for any remaining balance. All co-pays and deductibles are due at the time of service. You will be responsible for any attorney or collection fees incurred.

*****We accept cash, credit cards or checks*****

Your insurance policy is a contract between you and your insurance carrier. Please be aware that some of the services and/or supplies provided may not be covered by your insurance carrier. If you have any questions regarding the coverage, please contact your insurance carrier directly.

For assistance with billing questions, please do not hesitate to call us at (860) 395-5300.

Minor patients: A written consent form from parent or guardian is required prior to treating an unaccompanied minor.

Return Policy: Physical Therapy supplies are to be returned within 30 days from the date of purchase if there are fitting or manufacturing difficulties. This policy is contingent upon the condition of the returned item. Roberts Physical and Aquatic Therapy will not accept returns beyond 30 days. Custom fit supplies cannot be returned.

Cancellation Policy: In consideration of staff and other patients we ask you provide 24 hours notice when cancelling an appointment. A \$25.00 fee will be incurred for no-shows or for appointments cancelled without 24 hours notice. Notice of cancellation can be left on our voicemail within the appropriate time frame.

I have read the Financial Policy. I understand and agree to this Financial Policy:

Signature of Patient/Responsible Party Date

Guarantor (if different than patient): Address Phone# City State Zip



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SUBJECT: HIPPA NOTICE OF PRIVACY PRACTICE

ISSUE DATE: APRIL 2, 2007

ISSUED BY: SENIOR MANAGEMENT TEAM

POLICY STATEMENT: This notice describes how health information about you may be used and disclosed and how you can get access to this information.

PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact Todd Roberts, President of Clinical Services at (860)395-5300.

WHO WILL FOLLOW THIS NOTICE:

Roberts Physical and Aquatic Therapy

Acknowledgement of Receipt of this Notice

We will request that you sign this form or notice acknowledging you have received a copy of this notice. If you choose, or are not able to sign, a staff member will sign their name and date. This acknowledgement will be filed with your records.

Patient signature/Date



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Medical Release: I hereby assign all medical benefits to be paid directly to Roberts Physical and Aquatic Therapy.

I authorize disclosure of records to my insurance carrier, lawyer or referring M.D. and I also release any information necessary to process my claim.

Signature of Patient/Responsible Party

Date