KPTC
KERRVILLE
PHYSICAL THERAPY CENTER

Thank you for choosing our office! In order to serve you properly we need the following information. Please print. All information will be held confidential.

Patient Name:_____ -Male/Female- SS#_____
Date of Birth: _____ email:_____
Home Phone: _____ Cell Phone: _____
Physical Address: _____
Mailing Address:_____
City: _____ State: _____ Zip: _____
Parent's Name (If Minor): _____ Parent's SS#:_____
Name of School (If Student): _____
Referring Physician's Name:_____

PLEASE CHECK THAT YOU HAVE READ THE ITEMS BELOW

___ Is this a Work-Related Injury?
Yes___ (If yes please complete section underneath)
No___

WORKER'S COMPENSATION INFORMATION

Employer: _____ Address: _____
City/State/Zip: _____ Date of Accident: _____
Comp. Ins. Name: _____ Address: _____
City/State/Zip: _____ Phone: _____
Claim #:_____ Adjustor's Name: _____

___ Are you currently under the care of a Home Healthcare Agency?
Yes___ (Medicare will not pay for Physical Therapy if you are under Home Healthcare)
No___

___ Is this a Motor Vehicle Accident?
___Yes (Please fill out information below)
___No

MOTOR VEHICLE ACCIDENT INFORMATION

Date of Accident: _____
Responsible Parties' Insurance Information: _____

_Y / N_ Have you received any Outpatient Physical Therapy this year? If so Medicare has a cap of $1900/yr.

I hereby authorize my insurance benefits to be paid directly to Thomas C. Nemky, P.T. realizing that I am responsible for non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers and attorneys. It is my responsibility to check my insurance benefits although Kerrville Physical Therapy Center attempts to check benefits as a courtesy. Should I default on my financial responsibility and collection action is necessary, I will be responsible for collection costs that are incurred.

Signature: _____ Date: _____

# Medication List


| Medication | Dosage | Frequency | Route of Administration (Oral Etc.) |
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**Patient Signature** X _____ **Date** _____

# ***INFORMATION ABOUT YOUR MEDICARE BENEFITS***

If you are currently receiving Home Health Care Services, i.e. Nursing, Physical Therapy, or Occupational Therapy in your home, Medicare ***will not pay*** for your Outpatient Physical Therapy.

If a refund is requested from Medicare stating you were under the care of a Home Healthcare Agency while attending Kerrville Physical Therapy Center ***you will be responsible for the balance***.

Please check with your Home Health Agency to confirm you have been discharged before beginning any Outpatient Physical Therapy.

- Peterson Home Care (830) 257-3111
- Tri County Home Health (830) 895-3100

If you have a different agency please ask us for their contact information.

Patient's Signature_____Date_____

# NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____