



LeMars Physical Therapy
 789 Holton Drive
 PO Box 921
 LeMars, IA 51031
 (712) 546-1718
www.lemarspt.com

For Office use only:

resting HR: _____

resting BP: _____

Patient Medical History Form

Patient Name: _____ Date: _____

What are you seeking physical/occupational therapy for?(example: knee injury) _____

Is this a result of an injury that you had at work? No Yes

What date did you start to have problems? _____

What were you doing when this problem started? _____

Have you seen a doctor? No Yes Who? _____

What type of tests have you had?(circle) Xray MRI CT Scan Blood Work
 Other (please describe) _____

Have you had any other treatments for this? (circle) Ice Heat Rest
 Medicine(what kind) _____ Chiropractor Massage therapy
 Therapy (where) _____

Do you have any of these health problems right now? (circle) Cancer Diabetes
 High Blood Pressure Pregnant Asthma Shingles
 Arthritis(type and where) _____ HIV Hepatitis

Have you ever had any of these health problems? (circle) Cancer Diabetes
 High Blood Pressure Asthma Hepatitis
 Broken bone (where and when) _____
 Surgery (for what and when) _____

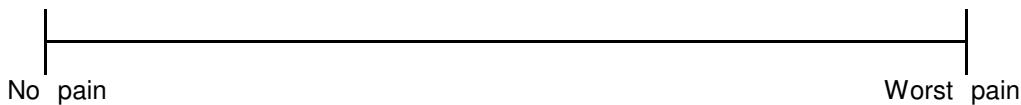
Are you having pain? No Yes

If so, where? _____

What makes your pain better? _____

What makes your pain worse? _____

Please mark on the line below, where your pain is at right now.





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Important Notices for Patients Receiving Physical Therapy and/or Occupational Therapy

Medicare

If you have received Medicare Home Health in the last three months, please tell us.

Medicare has implemented a cap for Outpatient Rehab Services, one cap that allows a total of \$1870.00 of allowed amount for both Physical Therapy and Speech Therapy and another cap of \$1870.00 for Occupational Therapy in 2011.

XIX-Iowa

There is a limitation of **\$1870.00 per year** for Physical Therapy Services and a limitation of **\$1870.00** for Occupational Therapy Services. **No Supplies are covered.** A co-payment may be required with your coverage as well and must be collected on the date the service is received.

Workman's Compensation

If under treatment on a Workman's Compensation claim, Physical and/or Occupational Therapy Services may be covered. These services must be authorized. If not, you may be responsible. **If you do not attend your appointment and do not call to cancel, your employer will be notified. If this should happen a second time, there will be a fee charged to your account. We will charge a \$50.00 fee for a half an hour time slot and a \$75.00 fee for a forty five minute time slot, so it is very important that you call if you cannot attend your scheduled appointment.**

General Notices

Certain restrictions may apply with your insurance company for Physical and/or Occupational Therapy Services. We advise you to contact your insurance company by using the toll-free number on the back of your insurance card to verify coverage. Some questions you may want to ask:

- Does my insurance cover Physical and/or Occupational Therapy?
- Are there any restrictions on where I can receive these services?
- Does the therapy need to be pre-authorized?
- **My treatment may call for "Iontophoresis" is this a covered under my Insurance Policy?**

If I cannot make my appointment, it is my responsibility to call and cancel. I understand that if I do not call to cancel, I risk being removed from any further scheduled appointments that I have made.

If your insurance company has any questions they may call Amy @ 712-546-1718.

I have read the above questions and I understand it is my responsibility to know my insurance policy and that I will check with my insurance should I have any questions or concerns.

Signature of Patient or Legal Guardian

Date



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Patient Consent Form - HIPAA

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by submitting your request in writing to LeMars Physical Therapy or by reviewing the current copy in our waiting room binder.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Signature

Date

Witness

Optional: Please restrict access to my personal health information (PHI) from:

Name

Address

Phone Number

Name

Address

Phone Number