

# Welcome to Mary Lou Corcoran Physical & Aquatic Therapy

## Patient Information Form – *Please complete entire form.*



### Personal Information

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/20\_\_\_\_  
First MI Last

SS #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  Male  Female

Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_ Primary Care Doctor: \_\_\_\_\_

Reason for Referral/Diagnosis: \_\_\_\_\_

How did you hear about Mary Lou Corcoran Physical Therapy?: \_\_\_\_\_

**Insurance Information** Type of Insurance:  Private Insurance  Workers Compensation  No Fault

### **WORKERS COMPENSATION & NO FAULT PATIENTS**

(Our office requires your private insurance be kept on file, we will not bill this insurance without notifying you first).

Private Insurance Carrier: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ DOB: \_\_\_\_\_ SS# \_\_\_\_\_

ID #: \_\_\_\_\_

### **MEDICARE PATIENTS**

➤ Have you had Home Health Care in the past 90 days? YES NO

If yes, which agency? \_\_\_\_\_ Date of Discharge: \_\_\_\_\_

Are you taking any medications now? YES NO If yes please list all medications below or attach list:

MEDICATION	REASON FOR TAKING MEDICATION

Do you have now, or have you ever had, any of the following conditions? Please check all that apply.

CONDITION	YES	NO	CONDITION	YES	NO
Are you pregnant NOW?			Allergy to tape/latex		
Electronic Implant			Bladder/bowel problems		
Pacemaker			Osteoporosis		
Rheumatoid Arthritis			Osteoarthritis		
High blood pressure			Heart problems		
Cancer			Seizures		
Diabetes			Asthma		
Alcoholism					

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Form 1110

I authorize Mary Lou Corcoran Physical & Aquatic Therapy to discuss my medical information with the following (indicate all that apply):

Spouse: \_\_\_\_\_ Phone #: \_\_\_\_\_

Family Member: \_\_\_\_\_ Phone #: \_\_\_\_\_

Doctor other than referring Dr.: \_\_\_\_\_ Phone #: \_\_\_\_\_

Attorney: \_\_\_\_\_ Phone #: \_\_\_\_\_

Other: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

Other: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

I hereby assign all medical benefits, to which I am entitled, including Medicare, private insurance, major medical and any other plan to Mary Lou Corcoran Physical & Aquatic Therapy, PC (MLCPT). I understand I am responsible for providing all of my insurance information. Medicare beneficiaries are responsible for charges in excess of the **\$1870.00 physical therapy cap**. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as **an original**.

**I understand that I am financially responsible for all charges whether or not paid by said insurance. I understand copay/coinsurance is due at the time of service and additional balances will be billed to me.** I understand it is possible that my fee for service may be different than the copay/coinsurance amount provided to me as a courtesy by MLCPT. I also agree to pay any and all attorney's and/or collection fees of a reasonable amount on the unpaid balance, if this account is referred to collection. I certify that the information given by me in applying for payment under title XVIII of Social Security Act is correct. I hereby authorize said assignee to use or disclose all information necessary for treatment, obtaining payment and health care operations.

I hereby authorize Mary Lou Corcoran, P.T. to perform any medical treatment as deemed necessary.

**I understand that as a patient I am responsible for maintaining a valid prescription and will contact my doctor's office to obtain an updated one when necessary.**

I have been notified that the HIPAA policy is posted in the waiting area and a copy of this policy is available to me upon request.

I have read and agree to the *Office & Financial Policies* and understand I am responsible for keeping a copy of this information.

\_\_\_\_\_  
Signature of patient or parent/guardian if minor

\_\_\_\_\_  
Date