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: ______________________________

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

Insurance Information

Type of Insurance: ❑ Private Insurance ❑ Workers Compensation ❑ No Fault

Please list *all* insurances. If you are a being treated for a Workers Compensation case or a No Fault claim please list the case/claim under Primary Insurance and your private insurance under Secondary Insurance Information.

Primary Insurance Carrier: ______________________________

Policy Holder: ______________________________ DOB: ______________ SS# ______________________

Insured's Employer: ______________________________

Secondary Insurance Carrier: ______________________________

Policy Holder: ______________________________ DOB: ______________ SS# ______________________

Insured's Employer: ______________________________

MEDICARE PATIENTS

➢ Have you received any physical therapy or speech therapy this year? YES NO

If yes, where: ______________________________ When: ______________________

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

If yes, which agency? ______________________________ Date of Discharge: ______________

Reason for Referral/Diagnosis: ______________________________

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

MEDICATION	REASON FOR TAKING MEDICATION

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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					

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: ____ Phone #: ____________________

Attorney: ____ Phone #: ____________________

Case/Claim Manager: ____________________________________ 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 **$1860.00 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 then 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 HIPPA 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 Policies.

____ ____________________

Signature of patient or parent/guardian if minor Date

Mary Lou Corcoran Physical & Aquatic Therapy

OFFICE POLICIES

- Upon arrival please sign-in at the front desk for each appointment.
- Copay/Coinsurance is due at the time of each appointment.
- Our HIPPA policy is posted in the waiting area, a copy of this policy is available upon request.
- Arrive 5 minutes early for each appointment to schedule your follow-up appointments and to pay copay/coinsurance.
- Notify the office 24 hours in advance if you are unable to attend an appointment.
- Patients are responsible for scheduling each appointment. We recommend scheduling appointments 1 week in advance.
- If a patient misses 3 appointments they may be discharged.
- Insurance companies require patients to have a prescription from their referring doctor to attend physical therapy. Prescriptions expire 30 days from the date the prescription was written (unless otherwise specified ie: 3 weeks or 6 weeks). Patients are responsible for contacting their Doctor to renew an expired/expiring prescription.
- Notify the front desk immediately of any changes in insurance, address or phone numbers.
- Patients are responsible for knowing their insurance benefits including, but not limited to copay/coinsurance, deductible, referrals, and visit limits.