Patient Intake Form

Are you on Home Health or Hospice? IF YES, please contact our office. If NO, please continue with the paperwork.

PERSONAL INFORMATION

Name:

Home Address:

City: State: Zip Code:

Home Phone : Work Phone:

Date of Birth: Cell Phone:

Email Address:

Emergency Contact: Emergency Contact Phone:

Would you like to receive appointment reminders?

How did you hear about us?

CONSENT TO TREAT

I hereby authorize the professional staff at Lystra Physical Therapy and Wellness to examine and treat me with physical therapy for the injury I have been referred here for or referred myself to.

Patient Signature:

Printed Name: Date:

Parent/Guardian Signature (if under 18): Date:

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO HEALTH PROVIDER

Insurance Company/Companies Name(s)_____

I hereby instruct the above-named insurance company/companies to pay by check made out to and mailed directly to: ***Lystra Physical Therapy and Wellness*** for professional /medical expenses allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY**.

This payment will not exceed my indebtedness to the above mentioned assignee and I agree to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment as required by my insurance policy.

*Your signature also indicates that you have received your insurance statement covering your benefits.

Patient Signature:

Parent/Guardian Signature (if under 18):

Printed Name: Date:

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NOTICE OF PRIVACY PRACTICES

I hereby authorize that I am aware of my rights as it pertains to HIPAA and my Protected Health Information (PHI). Lystra Physical Therapy and Wellness has offered me a copy of their Notice of Privacy Practices for my own records.

*If there is anyone you would like to authorize the disclosure of your appointments, medical or billing, you may specifically name the party below and indicate what information you would like to disclose:

1._____ entire medical record, diagnosis and medical treatment, and/or billing

2._____ entire medical record, diagnosis and medical treatment, and/or billing

Patient Signature:
(Parent signature if under 18)

Printed Name: Date:

Missed Appointment Policy

We strive to provide our patients with excellent service and quality care. Our commitment to your well –being and health care is something that we at Lystra Physical Therapy and Wellness take very seriously. Your commitment to your physical therapy program is critical to your success. We will recommend treatment and set goals for you. In order to reach those goals you must do your part and your most important part is to make each and every appointment.

We will give you an appointment card to keep track of your appointments. If you should misplace this, please give us a call to review your appointment dates. We expect you to keep all your appointments; however, should you need to cancel please note that we require a 24-hr notice.

- If you need to cancel, please call our office and reschedule. If you do not cancel with a 24-hour notice or if you do not show for an appointment you will be charged $30 for the missed appointment.
- If you miss 3 consecutive appointments, we will notify your physician and will require a new referral in order to continue your treatment.

We thank you for choosing Lystra Physical Therapy and Wellness and we are looking forward to working with you and helping you reach your goals.

The Staff at Lystra Physical Therapy and Wellness

**** I have read and understand this policy****

Patient Signature Date