ADVANCEDWELLNESS
LOUISIANA

Patient Admission Form

Patient Name: _____ **DOB:**_____
Address/Street:_____ **City:**_____ **State:**_____
Zip:_____ **Sex:** M/F **SSN**_____ **E-Mail:**_____
Home Phone: _____ **Cell:**_____ **Work Phone:**_____
Patient Employer:_____ **Responsible Party:**_____
Relationship to Patient :_____

IN CASE OF EMERGENCY CONTACT

Name:_____ **Relationship:** _____
Home: _____ **Cell:** _____ **Work:** _____

REFERRING PHYSICIAN

Name:_____ **Phone**: _____
Address:_____

PRIMARY CARE PHYSICIAN

Name:_____ **Phone**:_____
Address:_____

ACCIDENT INFORMATION

Is this condition due to an accident? Yes / No **Type of accident:** Auto/Work/Home
Have you made a report of your accident? Yes / No
Attorney Name:_____**Phone**:_____

PATIENT CONDITION

Reason for visit:_____
When did your symptoms appear?_____
Is this condition getting progressively worse? Yes / No / Unknown
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain):_____ **Describe pain in your own words:** _____
How often do you have this pain?_____

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PATIENT'S PRIMARY INSURANCE

Primary Insurance: _____ **Phone:**_____
Patients Name: _____
Policy Holder/Relation:_____
Policy Holder's Employer: _____
Policy Holder's SSN:_____ **Policy Holder DOB:**_____
Policy ID Number: _____ **Group Number:**_____
Covered Amount: / % Copay: $ Deductable: $
Has Deductible Been Met? Yes / No Referral Required? Yes / No
Pre-Auth/Pre-Cert Required? Yes / No
Pre-Auth/Pre-Cert Phone_____ Fax_____
Max # Visits:_____# Visits used on file:_____
Has Pt. had home health: Yes / No Start/End Date: _____
Any Policy Exclusions/Restrictions?_____
Insurance Person Contacted:_____ Contacted By:_____
MAIL CLAIMS TO:

_____

I HAVE READ THE INSURANCE VERIFICATION AND I UNDERSTAND THESE BENEFITS ARE NOT GUARANTEED. THE ABOVE IS AN ESTIMATE FOR MY INSURANCE COMPANY. MY CO-PAYMENTS AND % OF RESPONSIBILITY IS DUE AT THE TIME I AM TREATED. IF I OWN MORE THAN THE INSURANCE COMPANY ORIGINALLY QUOTED, I WILL BE RESPONSIBLE FOR THAT AMOUNT. IF I OVER-PAY MY BILL, I WILL BE REIMBURSED THE AMOUNT I OVERPAID ONCE I AM FINANCIALLY DISCHARGED. I HAVE RECEIVED A COPY OF THIS VERIFICATION FORM.

Patient Signature/Date:_____

Practice Rep/Date:_____

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Have you received any other treament for your condition? (Circle)
Medications/Surgery/Physical Therapy/Chiropractic Services/None
Other: _____
Previous Accidents: _____
Recent Procedures/Surgeries:_____
Recent Injections:_____
Restrictions with Activity/Exercise:_____
Previous Fractures:_____
Injury to: __Neck __Shoulder __Elbow/Hand __Spine __Hip __Knee __Leg __Ankle/Foot __Other(Describe)_____
Fractures:_____
Joint Replacement:_____
Please circle all medical conditions that apply to you:

Arthritis	Cancer	AIDS/HIV	Glaucoma	Anemia
Osteoporosis	Asthma	COPD	Shortness of Breath	Chest Pains
Congestive Heart Failure	Heart Attack	Hypertension	Neuro Disease	Stroke or TIA
Peripheral Vascular Disease	Cancer	Headaches	Depression, Anxiety	Incontinence
Kidney / Liver Disease	Back Pain	Visual Impairment	Hearing Problems	Pacemaker
GI Disease	Diabetes Type I or II	Prosthesis/ Implants	Sleep Disorder	Dizziness / Vertigo
History of Blood Clots	Numbness / Tingling	Weakness	Nausea	Fibromyalgia

Please list any other conditions:

_____

_____

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EXERCISE FREQUENCY:_____
WORK ACTIVITY: Sitting/Standing/Light Labor/Heavy Labor
HABITS: Smoking/Alcohol/Coffee/Caffeine/High
If Yes, Packs/Day_____ Drinks/Week_____
Drinks Cups/Day_____ Reason_____
Are you Pregnant? YES NO **Due Date:**_____
Medications:_____
_____
_____
_____
Allergies:_____

CONSENT FOR TREATMENT

I voluntarily authorize Advanced Wellness Louisiana to perform evaluations and procedures to administer outpatient physical therapy that in the opinion of the referring physician and/or consulting allied health provider is/are necessary and appropriate.

Patient Signature:_____**Date:**_____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize Advanced Wellness LLC. to obtain my Protected Health Information including: History and physical exams, lab reports, progress reports, X-Rays, and other radiography. I also authorize Advanced Wellness Louisiana LLC to release medical record information by means of telephone reproduction and/or fascmile transmission relative to any outpatient therapy treatment, evaluation, and/or medical services to the patient's referring physician for status of treatment. I also authorize for release of information to my primary care physician for providing follow-up care. I authorize the release of information to third party payors for charge verification.

PRIVACY NOTICE

By my signature below, I acknowledge that I have received a copy of this practice's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law and understand my rights as a patient regarding my personal health information.

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PATIENT MISSED APPOINTMENT POLICY

We strive to provide our patients with the utmost professionalism and excellence of service. Therefore, we have certain rules that need to be followed in order to ensure the most optimum results.

In an instance of cancellation, without 24 hours notice, we reserve the right to charge you a $25.00 fee. In an instance of a no-show we reserve the right to charge you a $50.00 fee. After the second no-show or third cancelled appointment all future appointments will be removed from the schedule and you will be added to our "same day appointment only" list.

In instances of repeated non-compliance with your scheduled visits, we reserve the right to discontinue care and will inform your physician of the fact that your service has been discontinued secondary to non-compliance with the prescribed rehabilitation order.
By signing, Patient agrees and understands all items outlined above.

Signature of Insured/Patient _____ **Date** _____

Practice Representative_____ **Date** _____

Assignment of Benefits

I acknowledge that I accept liability for payment of all charges incurred during the course of my treatment that are either not paid or denied by my insurance. I authorize the release of all medical and other information necessary to process claims relevant to my medical care for services rendered by Advanced Wellness Louisiana LLC. I authorize payment to Advanced Wellness Louisiana LLC for services rendered and understand that their participation with my insurance plan will not guarantee payment for services provided. I agree to pay any balance remaining after my claim has been processed. I understand that some services may be denied by my insurance company (due to plan and/or policy limitations). **By signing below, I acknowledge that I understand my obligations.**

Patient Signature _____ Date_____

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Financial Policy

We will contact your insurance provider prior to your initial evaluation to determine your insurance benefits. Please remember that the benefits quoted by your insurance company is not a guarantee of payment. The undersigned is ultimately responsible for payment of expenses incurred if your insurance does not cover the provided treatment(s). We advise that you become familiar with your therapy benefits provided by your insurance prior to treatment. Your insurance policy is a contract between your insurance company and you; Advanced Wellness Louisiana LLC is not part of this contract. **Please notify Advanced Wellness Louisiana if you have a change in insurance during the time of your treatment.**

If your claim has not been processed within thirty (30) days, we request that you contact your insurance company to help expedite the process.

If Advanced Wellness Louisiana is quoted differently than your claim is processed, you will be notified. You are responsible for payment in full once your claim has been processed and either payed or denied. If your claim has been denied, you are still responsible for payment of services rendered. It is your responsibility to follow up with your insurance company regarding denial of claim. Not all services and diagnosis codes are a covered benefit by insurance providers. With this being said, we will not base treatment off of insurance providers “fee schedule” but will inform you if suggested treatment/services are not covered by your insurance provider.

**You will be held 100% responsible for payment due to Advanced Wellness Louisiana LLC if at any time during your treatment your insurance determines that your injury is due to an accident and insurance refuses payment

Advanced Wellness Louisiana takes pride in the unmatched services we provide to our clients. In order to maintain the same level of care to our patients, we expect payments rendered for services in a timely manner. If it becomes evident that a patient has no intention of paying an outstanding balance for services rendered, an attorney and/or collection agency will be contracted to ensure payment of balance and a collection fee will be charged to the patient’s neglected account.

I have read and agree to the Financial Policy of Advanced Wellness Louisiana

Patient/Responsible Party: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

As part of my health care, **Advanced Wellness Louisiana** (**Advanced Wellness Louisiana**) creates and stores information about me. This includes records concerning my health history, symptoms, examinations, test results and plans for future care.

I understand that this information serves as a basis for my continuing care. I understand that this information is used as a means of communication among **Advanced Wellness Louisiana**'s personnel, and with medical personnel outside of this practice. I understand that this information serves as a source of information for applying my diagnoses and surgical information to my bill.

I understand that this information is a way for third party insurance companies to assure that a service we billed for was actually performed.

I understand that this information can be used as a tool to assess the quality of care provided to patients. I have been provided an opportunity to review the Notice of Privacy Practices for **Advanced Wellness Louisiana** that provides a more complete review of information uses and disclosures. I understand that I have the right to review this Notice of Privacy Practices before signing this consent.

I understand that **Advanced Wellness Louisiana** may change its Notice of Privacy Practices at any time and that a current copy will be available for my inspection during regular business hours of each medical office and at the central billing office.

I understand **Advanced Wellness Louisiana**, for **Workman's Compensation Cases**, will release the minimum necessary PHI/ePHI to your employer, your worker's compensation insurance carrier, third party administrator, rehab nurse or nurse case manager unless otherwise restricted below.

I understand that I have the right to request restrictions as to how my information may be disclosed to carry out treatment, payment or other healthcare operations and that **Advanced Wellness Louisiana** is not required to agree to the restrictions requested. The procedure to request restriction on information use and disclosure is contained in the Notice of Privacy Practices.

I DO NOT authorize my information shared with the following individuals or organizations (enter names below and initial the box):

_____

I DO authorize my information shared with the following individuals or organizations (enter names below and initial the box):

_____

I acknowledge that I have received a copy of the Notice of Privacy Practices of Advanced Wellness Louisiana and agree to the liability limitations explained therein.

_____ _____ _____

Signature of patient or legal representative | Date | Relationship to Patient

_____

Printed name of patient

Effective date April 14, 2003

Revised date September 23, 2017