Start of Care:_____

JTS

Patient Information

Patient Name:_____DOB:_____ Home Phone: (_____) _____-_____
First Last MI

Address:_____ Cell Phone: (_____) _____-_____

City:_____ State:_____ Zip:_____ Work Phone: (_____) _____-_____

Sex: M or F Marital Status: M S W D SS #_____

Employment Status

Employer:_____ Work Status: FT PT Retired Student

Employer Address:_____

City:_____ State:_____ Zip:_____ Contact person:_____
(If work related injury)

Injury Information

Was your injury due to an accident? Yes No Accident/Injury date:_____

Type of accident/injury: Auto Accident-(if yes, state in which accident occurred____) Work related Sports Personal Liability
Accident/injury location:_____
Injury Details:_____
_____
_____

☐ **Primary Insurance Holder Information** – if different from patient information above.

-or-

☐ **Secondary Insurance Holder Information** – if different from patient information above.

Name:_____DOB:_____ Home Phone: (_____) _____ - _____
First Last MI

Address:_____ Cell Phone: (_____) _____ - _____
Work Phone: (_____) _____- _____

City:_____ State:_____ Zip:_____ Sex: M or F
Relationship to patient:
Spouse Parent Other:_____

Employer:_____ Work Status: FT PT Retired

Address:_____

City:_____ State:_____ Zip:_____

Emergency Contact

☐ Same as insurance holder information listed above (if same, do not need to fill out)

Name:_____ Home Phone: (_____) _____-_____
Relationship to patient:_____ Cell Phone: (_____) _____-_____

PATIENT MEDICAL HISTORY

Name:_____ Referring Physician:_____
Family Physician:_____ Date of Onset: _____
Last Date Worked Due to this Injury:_____ Date Returned to Work after this Injury:_____

Have you had Surgery for this injury? **YES** **NO** Number of Surgeries: 1 2 3 4 _____
Date of Surgery:_____ Type of surgery: _____

Are You Currently Taking Any Prescription or Non-Prescription Medications? **YES / NO** **Current Height:**_____ **Weight:**_____
Please List Medications:

Medication	Dose	Frequency	Oral/Other	Medication	Dose	Frequency	Oral/Other

Are You Allergic to any Medications? **YES** **NO** List Medications: _____

Have you had any of the following Medical or Rehabilitative Services for this Injury/Episode?

	YES	NO		YES	NO
Chiropractor	___	___	CT Scan	___	___
EMG/NCV	___	___	General Practitioner	___	___
Massage Therapy	___	___	MRI	___	___
Myelogram	___	___	Neurologist	___	___
Occupational Therapy	___	___	Orthopedist	___	___
Physical Therapy	___	___	Podiatrist	___	___
Emergency Room Care	___	___	X-Rays	___	___

Do you now have or Have you ever had ANY of the following?

	YES	NO		YES	NO
Asthma, Bronchitis, or Emphysema	___	___	Severe or Frequent Headaches	___	___
Shortness of Breath/Chest Pain	___	___	Vision or Hearing Difficulties	___	___
Coronary Heart Disease or Angina	___	___	Numbness or Tingling	___	___
Do you have a Pacemaker?	___	___	Dizziness or Fainting	___	___
High Blood Pressure	___	___	Bowel or Bladder problems	___	___
Heart Attack or Surgery	___	___	Weakness	___	___
Stroke/TIA	___	___	Weight Loss/Energy Loss	___	___
Congestive Heart Disease	___	___	Hernia	___	___
Blood Clot/Emboli	___	___	Vericose Veins	___	___
Epilepsy/Seizures	___	___	Allergies	___	___
Thyroid Disease or Goiter	___	___	Any Pins or Metal Implants	___	___
Anemia	___	___	Joint Replacement Surgery	___	___
Infectious Diseases	___	___	Neck Injury/Surgery	___	___
Diabetes	___	___	Shoulder Injury/Surgery	___	___
Cancer or Chemotherapy/Radiation	___	___	Elbow/Hand Injury/Surgery	___	___
Arthritis	___	___	Back Injury/Surgery	___	___
Osteoporosis	___	___	Knee Injury/Surgery	___	___
Gout	___	___	Leg/Ankle/Foot Injury/Surgery	___	___
Sleeping Problems/Difficulties	___	___	Are You Pregnant?	___	___
Emotional/Psychological Problems	___	___	Do You use Tobacco?	___	___

List any other information that would assist us in your care: _____

_____

What are your rehabilitation expectations/goals?_____

atient/Guardian Signature:_____ Date: _____

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for **Jacobsen Therapy Services, LLC,** to furnish medical care and treatment to _____ considered necessary and proper in diagnosing or treating his/her physical condition.

BENEFIT ASSIGNMENT / RELEASE OF INFORMATION

I, hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance and third party payers to **Jacobsen Therapy Services, LLC**. A photocopy of this assignment is to be considered as valid as the original. I, hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment. I further authorize release to any physicians, hospitals, or others who may require such records in connection with my current condition.

FINANCIAL POLICY STATEMENT

I agree to pay promptly and fully all charges for services and supplies provided by **Jacobsen Therapy Services, LLC,** at their regular rates and terms. We will bill your insurance company as a courtesy to you and will bill you on a monthly basis for any balance due after insurance payments and adjustments have been applied. I further agree to pay any charges, which for any reason, are not covered or not promptly paid by insurance. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company.

I understand that it is my responsibility to obtain any prior approvals required by my insurer, and to take all other steps to qualify for insurance coverage. I will determine whether my insurer requires pre-certification before I receive therapy services.

If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit same to **Jacobsen Therapy Services, LLC.**

The above does not apply for those patients that are considered Worker's Compensation. However, be advised if you claim W/C benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees. A service charge of 1% per month will be added to all charges which remain unpaid after 90 days.

NOTICE OF PRIVACY PRACTICES

You have a right to notice of our privacy practices with respect to your health information, including a paper copy of this Notice of Privacy Practices if requested.

CONTINUED OUTPATIENT CARE

Proper treatment of a medical condition often requires continuing treatment of a diagnosis over a course of repeated outpatient visits. This consent and the agreements contained herein shall apply to all repeat visits and all continuing treatment for the same condition as well as any added diagnoses. Jacobsen Therapy Services, LLC, will keep this consent on file indefinitely for services requested at Jacobsen Therapy Services, LLC, for any care requested thereafter for the same diagnosis/condition or new diagnosis/condition. A new consent for care and treatment will only be required to notify you upon changes to the content contained herein.

_____ _____

Signature Date

_____

If signing for patient, state relationship and authority

_____ _____

Center Representative/Witness Date

JTS

Medicare Secondary Payer Questionnaire

Patient Name:_____ **DOB:**_____

Center for Medicare services requires this to be completed by all Medicare patients.

1. Are you entitled to Medicare on the basis of age? . . . . . YES NO

2. Are you entitled to Medicare on the basis of a disability? . . . . . YES NO

3. Have you received Home Health Care of any kind in the past 60 days? . . . . . YES NO
   HHA name:_____ Phone#:_____

4. Are you entitled to benefits under the Black Lung Program, Veterans Administration, or other government program?. . . YES NO
   If **YES**, please provide the following information:
   Program name:_____
   Address:_____
   City, State & Zip:_____

5. Was you illness/injury due to an accident? . . . . . YES NO Date:_____
   Type: Work Auto On property other than your own
   Please give details of the accident:_____
   _____

   Please provide the name, address, and contact information of the liability insurance:
   Insurance name:_____
   Address:_____
   City, State & Zip:_____
   Phone:_____Contact:_____

Medicare regulations require us to file with the above liability insurance first, even if they will not pay directly or immediately. We must comply with this regulation before filing Medicare and appreciate your cooperation.

Do you feel you have a right to be compensated by a party who may have caused the injury or illness? . . . . . YES NO
If **YES**, do you intend to file a liability claim or lawsuit in connection with his injury or illness? . . . . . YES NO
If **YES**, please provide the attorney information:
Attorney name:_____
Address:_____
City, State & Zip:_____
Phone:_____Employer:_____
Insured's name:_____

6. If you have received a kidney transplant or are currently receiving dialysis for End Stage Renal Disease, please give the date of the transplant or start of dialysis. Date:_____
   If date is less than 18 months ago, are you currently covered under group insurance provided by you or a family member's employer?
   YES – the group insurance will be primary
   NO - Medicare will be primary

7. Do you have group insurance coverage through you or a family member's employer?
   YES – the group insurance will be primary
   NO - Medicare will be primary

If you answered "YES" to question 6 or 7, please provide the group insurance information.

Insurance name:_____
Address:_____
City, State & Zip:_____
Phone:_____Employer:_____
Insured's name:_____

Thank you for your cooperation!

_____ _____
Patient's Signature Date

_____