



Your Health, Your Choice, Our Priority

2123 E. 23rd Ave. South • Fremont, NE 68025 • P: (402) 721-1112 • F (402) 721-1113
1515 South 204th Street, Suite 105 • Elkhorn, NE 68022 • P: (402) 620-4605 • F: (402) 620-4606

Patient name: _____ Birth Date: ____/____/____

Address: _____ City: _____ State: _____ Zip Code: _____

Social Security # _____ - _____ - _____ Sex: M F Marital Status: S M D Other

Email: _____ Home # _____ Cell Phone# _____

Appointment Reminders (Choose One) Phone call Text Email

Employer: _____ Address: _____ Phone # _____

****List of Medications Required**

Person Responsible for Bill (If different than patient) _____

Birth Date: ____/____/____ Phone #: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Social Security # _____ - _____ - _____ Sex: M F Marital Status: S M D Other

Employer: _____ Address: _____ Phone # _____

Patient a Student: Y N School: _____

Referring doctor: _____ Next Appt: _____

Body Part being treated: _____ How did you hear about us: _____

Date of injury/onset: _____ Date of Surgery: _____

Person to notify in case of emergency-

Name: _____ Relation: _____ Phone #: _____

Insurance-

Primary Insurance: _____ ID#: _____ Group #: _____

Policy Holder Name: _____ **Birth Date:** ____/____/____

Social Security #: ____/____/____ Sex: M F Relationship to patient: _____

Secondary Insurance: _____ ID# _____ Group# _____

If Auto or Work Comp: Adjuster's name: _____ Clm#: _____

HIPAA and Communication Authorization Form

Patient Name: _____ SSN _____

I have read and understand the HIPAA NOTICE OF PRIVACY PRACTICES provided to me by Nebraska Orthopaedic Physical Therapy P.C. This notice describes how my medical information may be used and disclosed and how I can get access to the information. I understand that a copy will be provided to me upon request.

Name

date

The Physical Therapists at Nebraska Orthopaedic Physical Therapy, P.C. strive to communicate with each patient in an effective and professional manner. Our policy states that all communication between you and your therapist is completely confidential. However, there may be some cases that your family member, friend, or others might be involved with your care as a patient and you may want us to communicate directly with them. In order to follow our policy and protect the privacy of your personal health information, please list any and all names of people with whom your therapist can discuss your health information with.

Name _____ Relation _____

Name _____ Relation _____

Name _____ Relation _____

Name _____ Relation _____

I fully understand that the people above can receive my private health information if needed.

Date

Patient Signature

Guardian Signature (if needed)

WELCOME TO NEBRASKA ORTHOPAEDIC PHYSICAL THERAPY, P.C.

We are committed to providing you with the best possible care. If you have medical insurance, we are eager to help to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy.

If you have insurance, we will be happy to file your insurance claims, however, it is your responsibility to make sure the claims are being paid in a timely manner. While we are able to verify insurance coverage, most insurance carriers will not guarantee payment until they receive the claims and diagnosis. Your coverage maybe subject to limitations and we encourage you to check with your insurance company regarding your particular plan.

MEDICARE GUIDELINES

If you have received home health or outpatient physical therapy through another clinic, please advise us.

A written referral signed and dated by your physician is required. There must be evidence in the clinical record maintained by the therapist that a physician has seen the patient at least every 30 days. Therefore, it is the patient's responsibility to make an appointment with his/her referring physician every 30 days from the date of the initial evaluation, in order for Medicare to reimburse for the services rendered.

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patient, all charges are your responsibility from the date the services are rendered.

Payment is due at the time of services are rendered unless payment arrangements have been approved in advance by our staff. This includes charges not covered by insurance, co-pays, deductibles, coinsurance, and durable- medical equipment. We accept cash, check or credit card.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Our office requires a 24-hour notice for cancellation of appointments; you can call and leave a message on the answering machine if needed. We realize conflicts with work, other activities, or unexpected illness may require you to call and reschedule, however, there will be a \$25.00 charge for a missed appointment without notification to the office. This may be waived if the appointment is made up within the same week. _____*

If you have any questions, **PLEASE** do not hesitate to ask us. We are here to help you and appreciate that you have chosen our clinic for your care.

Thank you,

Nebraska Orthopaedic Physical Therapy, P.C.

Signature

Date

Parent (if minor)

Date