

PTOS # \_\_\_\_\_

Therapist \_\_\_\_\_

Appointment Date \_\_\_\_\_

Scheduler \_\_\_\_\_

Appointment Time \_\_\_\_\_

**1. Patient information**

Patient name	Patient employer <input type="checkbox"/> Not employed <input type="checkbox"/> Retired
Address	Employer address
City/state/zip	City/state/zip
Phone number	Employer phone number
Social security number	Occupation
Age      Date of birth      Gender <input type="checkbox"/> M <input type="checkbox"/> F      Marital status	Length of employment
Referring physician	Referring physician phone number

**2. Party responsible for the bill— Same as above (this area must be filled out if the patient is < 18 years old)**

Name of person responsible for payment	Relationship to patient
Address	Employer
City/state/zip	Employer address
Social security number	City/state/zip
Date of birth	Employer phone number
Home phone number	Occupation

**3. Emergency information**

Name of person to contact	Relationship to patient
Emergency contact phone number	
Address (optional)	Family physician
City/state/zip (optional)	Family physician phone number

**4. History of condition**

Diagnosis for which therapy is ordered	Number of visits ordered
Is condition due to an injury? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, date of injury	
How injury occurred (If MVA fill out section #8)	
Have you had previous treatment for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, when and where?	
Have you had therapy for ANY condition this year? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, when and where?	
Have you ever had treatment at a Concorde facility? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, when and where?	
Is this condition work related? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, was work missed? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, dates of missed work (If work related, complete section #9)	

**5. Medicare** Primary Secondary Other

Medicare number	Have you recently received care from a Home Health Agency? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which agency?
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**6A. Commercial Insurance** Primary Secondary Other

Name of insurance company	Name of insured
Billing address	Relationship to patient
City/state/zip	Insured's social security number
Phone number	Insured's date of birth
	Policy number
Employer of insured	Group number

**6B. Commercial insurance** Primary Secondary Other

Name of insurance company	Name of insured
Billing address	Relationship to patient
City/state/zip	Insured's social security number
Phone number	Insured's date of birth
	Policy number
Employer of insured	Group number

**7. Medicaid** Primary Secondary Other

Case name	Billing number (12 digits)
Current eligibility dates	Case manager

**8. Motor Vehicle Accident Personal Injury \_\_\_\_\_Med Pay Insurance Third Party Insurance**

Name of insurance company	Adjuster
Insurance Address	Claim number
City/state/zip	Insurance company phone number
Do you have an attorney? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of attorney	Attorney address
Attorney phone number	City/state/zip
Patient has been informed about the \$50.00 deposit. <input type="checkbox"/> Yes <input type="checkbox"/> No	

**9. Workers Compensation** Self Insured MCO

Date of injury	Claim number for this condition
Date of script	Name of employer at the time of injury
Do you have an authorization for treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, has authorization been requested? <input type="checkbox"/> Yes <input type="checkbox"/> No	Physician of record
If Timken employee: Plant number	Clock number

I agree that the information contained on this form is correct. I give my permission to release records, including reports, evaluations, progress notes, plans of care and billing information to those listed in sections 1, 2, 5, 6, 7, 8 and 9. Do not release information to \_\_\_\_\_.

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_