

MILLENNIUM Physical Therapy

division of Millennium Medical Group, P.C.

PATIENT INFORMATION

Welcome to our office. The following information is considered confidential.

Today's Date: _____

Name: _____ D.O.B.: _____

Name of Spouse (or parent, if child): _____

Street/Apt.: _____ Phone #: _____

City: _____ State: _____ Zip Code: _____

Soc. Sec. #: _____ Employed by: _____

Employer's Address: _____ Phone #: _____

City: _____ State: _____ Zip Code: _____

Next of Kin: _____ Relationship: _____ Phone #: _____

Person legally responsible for Account: _____ Relationship: _____

Address: _____ Phone #: _____

City: _____ State: _____ Zip Code: _____

Who may we thank for referring you to our office? _____

Address: _____ Phone #: _____

City: _____ State: _____ Zip Code: _____

Primary Physician: _____ Phone #: _____

Address: _____

Chief Complaint: _____

Date of onset: _____

Is this an Auto Accident: YES NO If Yes, Date of Accident: _____

Is this Employment Related? YES NO If Yes, Date of Occurrence: _____

Is this an Injury? YES NO If Yes, Date of Injury: _____

Are you receiving visits from a Home Health Care Agency? YES NO

If Yes, what is the name of the agency: _____

DO YOU HAVE AN ATTORNEY? YES NO

ATTORNEY'S NAME: _____

28625 Northwestern Highway, Suite 100, Southfield, MI 48034

COVERAGE FOR SERVICES IN THIS OFFICE WILL BE:

BLUE CROSS / MEDICARE

Patient's Name:

HIC#:

Insurance: Blue Cross / Blue Shield Group:

Other Name:

Contact #:

Group#:

If Medicare, is your spouse employed?

YES

NO

OTHER

Carrier Name:

Work. Comp.:

Other:

Policy Number:

Group:

Name of Company:

Address:

City:

State:

Zip Code:

**PATIENTS CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION
AND PAYMENT REQUEST.**

I authorize holder of medical or other information about me to be released to the Social Security Administration and/or Medicare program or its intermediaries or carriers or to the professional standard review organization, any information needed for this or a related Medicare claim. I certify that this information given by me in applying for payment is correct and I request that payment of authorized benefits may be made on my behalf.

Signature (patient or Authorized Rep.)

Date

Witness Signature(s)

Date

Witness full name & Identification

Patient's Name:

Medical Record#:

Date of Admission:

My signature on this form acknowledges that I have received a copy of MMG Physical Therapy's Notice of Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by MMG Physical Therapy and of my rights with respect to my health information.

I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health.

Patient's Signature

Date

Signature of Patient's Representative (if patient is unable to sign)

Date

For Office Use Only:

If above is not signed by patient:

1. Was the patient provided with a copy of the Clinic's Notice of Privacy Practices? YES NO

2. Briefly describe efforts made to obtain the patient's acknowledgment of receipt of the Notice and explain why the patient was not able or willing to sign this form.

Signature of Office Personnel

Date

Service:

P.T.:

Other:

Date of Evaluation:

Billing Information Verified:

Dr. Order Recd/Script #:

Comments:

Referral Source Contacted:

Date:

Discharge Date:

Discharge Communicated to:

Referral Source:

Date:

Physician:

Date:

Other:

Date:

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In consideration of your undertaking to treat me, I agree to the following:

AUTHORIZATION TO RELEASE INFORMATION

You are authorized to release my medical records to any insurance company, attorney, physician, adjusters and consultants, in order to process any claim(s) for reimbursement of charges or other legal purposes as a result of the professional services rendered by you and I hereby release you of any consequences thereof.

ASSIGNMENT OF ACTION

In the event that any insurance company is obligated by contractual agreement to make payment to me or you for the demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the names(s) of which is/are believed to be correctly set forth under pertinent data below) and authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company (or companies) contractually obligated, you will refrain from attempts and efforts to collect the amounts you do not collect from insurance proceeds (whether it be all or part of what is due), I personally owe you and agree to pay in a current manner.

AUTHORIZATION TO PAY DIRECTLY TO PHYSICAL THERAPIST

In consideration of the physical therapy services rendered and to be rendered by them, I authorize and direct the payment to the therapist named above of any sum I now or hereafter owe them by you, my attorney, out of the proceeds of any settlement of my case and /or by any insurance company obligated to reimburse me for the charges, for the services or otherwise obligated to make payment to me based in whole or in part upon the charge made for his services.

ACKNOWLEDGMENT AND UNDERSTANDING

I hereby acknowledge that I am receiving (or about to receive) care services at MMG Physical Therapy and that I have been advised that the therapist providing the services is willing to wait for payment for these services, provided that there continues to be a reasonable chance that payment will be made either by the insurance proceeds or out of the settlement of a liability case.

I understand that if it is determined either:

1. That there is no insurance company obligated to pay for the services, or if the insurance company involved refuses to acknowledge an assignment to the therapist; or make provisions for the protection of the interest of the therapist;
2. If a liability claim exists and my attorney refuses to agree to protect the interest of the therapist; or if I have not engaged in service of an attorney;

then payment of the services rendered by the therapist at MMG Physical Therapy, will be made on a current basis and my bill paid in full as my liability claim is settled or the passage of three months from my last treatment, whichever comes first.

Dated the _____ day of _____ 2009

Patient's Signature: _____

Witness: _____

Date: _____

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SOCIAL WORKER PROGRAM

We are interested in the total well being of our patients. In keeping with this philosophy, we feel that Social Worker intervention for psychological needs may sometimes be appropriate during your rehabilitation. You, your physician, therapist, and our qualified social worker might agree that this service may be helpful. The social worker is available to evaluate the social or vocational factors involved in your rehabilitation, to counsel and advise you on special problems arising from your illness or injury, and to make appropriate referrals for required services, if any. Help is available for the following:

- Financial**
- Vocational**
- Social**
- Family Matters**
- Emotional**

Do you wish to meet with our social worker?

YES NO

Please ask your therapist any questions if you would like further explanation.

Patient's Signature

Date