"We treat you like family"

LOW COUNTRY
Physical Therapy

Voted "Best Physical Therapy Center" by the Myrtle Beach Herald

Welcome to Low Country Physical Therapy,

Your appointment is scheduled on _____ ____/ ___/ ___ at ____:____AM/PM.

It is the mission of Low Country Physical Therapy and its staff to provide therapeutic and restorative services to patients for the rehabilitation of injured, disabled, or sick; to assist each patient in reaching his/her maximum performance so he/she may resume his/her rightful place in the society while learning to live within the limits of his/her capabilities. Low Country Physical Therapy shall provide state-of-the-art health care that strives to significantly improve the well being of each patient, while recognizing their capacity of being responsible for their own health.

All patient co-pays and balances are due prior to treatment. We accept the following forms of payment: cash, check, Visa, MasterCard, Discover, and American Express.

Enclosed you will find your new patient paperwork you will need to complete in blue or black ink only, and bring with you the day of your appointment. Make sure you also bring the following items:

1. **Driver's license**
2. **Insurance card(s)**
3. **A current list of medications including anything that is over the counter with the milligrams, how many times a day you take each one, how each one is taken, and the reason you are taking each medication**.

If your physician has given you the script for your therapy, it is necessary for you to bring this with you as well, as some insurance companies will not allow us to treat you without it.

You should wear something comfortable so the therapist will be able to access the individual body part(s) necessary for your treatment. We have included a map with directions on the back of this page. If you have any questions please call us at (843)651-6565 or (843)314-3980.

We look forward to treating you and helping you reach the goals set forth by you, your physician, and your therapist.

Thank you,
Low Country Physical Therapy

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Two Convenient Locations!

Garden City Office
2586 Hwy. 17 Business
Garden City Beach, SC 29576
p: 843.651.6565
f: 843.651.6575

Directions:
Located in the Garden City Area of the Grand Strand. It is on the west side of 17 Buiness between Glenns Bay Road in Surfside Beach and the Garden City Connector, opposite St. Michael Catholic Church.

Litchfield Office
267 Willowbrook Blvd. Suite D
Pawleys Island, SC 29585
p: 843.314.3980
f: 843.314.3979

Directions:
Located in the Pawleys Island Area of the Grand Strand. From our current office continue south on Hwy. 17 Bueiness or Ocean Highway. Turn right onto Willbrook Blvd. and new office is on the left, the 3rd entrance into Mingo Plaza next to Quigley's Pint & Plate.

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Patient Information: Verified DL: ☐ Yes ☐ No

Last Name: First Name: Middle Initial:

Address: City: State: Zip Code:

Home Phone: Cell Phone: E-mail Address:

Date of Birth: SSN: Sex: ☐ Male ☐ Female Marital Status:

I would like to receive appointment reminders by: ☐ Text Message ☐ By E-mail

Employer Information:

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Student

Employer Name:

Address: City: State: Zip Code:

Work Phone Number: Patient Occupation:

Emergency Contact Information:

Contact Name:_____ Phone Number:_____

Relationship to Patient:_____

Emergency contact is permitted to discuss the medical conditions of the patient: ☐ Yes ☐ No

Physician Information:

Name of Referring Physician:_____ Family Doctor_____

Additional Questions: ☐ Auto Related: ☐ Work Related:

COMMERICAL AND MEDICAID INSURANCES ONLY:

Have you received PT, OT, or Speech therapy services this year and or last year? ☐ Yes ☐ No

If yes, name of facility_____

If yes, when? and how many visits? _____

MEDICARE ONLY - Additional Questions

If Medicare, are you currently receiving Home Health Services? ☐ Yes ☐ No

If yes, name of Agency _____

If yes, what type of Home Health Services are you receiving? _____

Last date of service: _____/_____/_____

Are you currently residing in a skilled Nursing Facility? ☐ Yes ☐ No

If yes, facility name: _____

If Medicare, have you received PT, OT, or Speech therapy services since the first of the year? ☐ Yes ☐ No

If yes, do you know if you have exceeded your Medicare Therapy Cap Amount? ☐ Yes ☐ No

(Please continue on reverse side)

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Insurance Information: Same as card ☐

Last Name: First Name: Middle Initial: SSN: DOB:

Patient relationship to Policy Holder: Gender: ☐ Male ☐ Female

Employer Name:_____ Employer Phone:_____

Primary Insurance Section: Secondary Insurance Section:_____

Payor/Plan:_____ Payor/Plan:_____

Policy #/ID#:_____ Policy #/ID#:_____

Group#:_____ Group#:_____

I consent to Low Country Physical Therapy for treatments/procedures that are necessary or advisable for my care. I hereby grant authorization to Low Country Physical Therapy to exchange with and or release requested information on my medical care to my insurance carrier(s) and to:

☐ Workers Compensation ☐ Patient/Guardian ☐ Attorney

The above description is a quote of your insurance(s) benefits. We assume no liability for any errors made by your insurance carrier(s) in this quotation. It is your responsibility to clarify any discrepancies in eligibility and benefits and or authorization and inform our clinic immediately. We cannot exactly determine what your insurance company allows until insurance processes based on your contract with your insurance carrier. You are responsible for all charges incurred, regardless of payment by your insurance company; any balance due/charges not paid by your insurance company become your responsibility. If no payment is made on your account it will be forwarded to collections.

I have read and understand Low Country Physical Therapy's privacy notice. I further understand that I may obtain a copy of this privacy notice upon my request. ☐ Yes ☐ No

I have read and understand Low Country Physical Therapy's billing and collection policies, initial disclosure, and cancellation and no show policies. I further understand that I may obtain a copy of this policy upon my request. ☐ Yes ☐ No

Patient Signature:_____

Date:_____/_____/_____

Responsible Party's Signature (if patient is a minor)_____

Date:_____/_____/_____

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Date: _____/_____/_____

Patient Name: _____Referring Physician: _____

Is the reason for your visit today due to a motor vehicle accident? ❍ Yes ❍ No

Is the reason for your visit today related to a work injury? ❍ Yes ❍ No

What is your main complaint or reason for coming to therapy?

When did this condition begin?

Have you had any tests or surgery for this condition?

What tests have you had done?

What are you having difficulty doing because of this condition?

What relieves your symptoms?

What aggravates your symptoms?

On a scale of 0 – 10 (0=no pain, 10=emergency room pain):

Best pain in the last 24 hours:_____Worst pain in the last 24 hours:_____

Office Use Only:
Estim Code: ☐ 97014 ☐ G0283

(Please continue on reverse side)

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Past Medical History:

Allergies	☐ Yes	Currently Pregnant	☐ Yes	Kidney Problenis	☐ Yes
Alzheimer's	☐ Yes	Depression	☐ Yes	Multiple Sclerosis	☐ Yes
Anemia	☐ Yes	Metal Implants	☐ Yes	Muscular Disease	☐ Yes
Anxiety	☐ Yes	Diabetes	☐ Yes	Osteoporosis	☐ Yes
Arthritis	☐ Yes	Dementia	☐ Yes	Parkinson	☐ Yes
Asthma	☐ Yes	Dizzy Spells	☐ Yes	Rheumatoid Arthritis	☐ Yes
Autoimmune	☐ Yes	Emphysema/Bronchitis	☐ Yes	Seizures	☐ Yes
Disorder	☐ Yes	Fibromyalgia	☐ Yes	Smoking	☐ Yes
Cancer	☐ Yes	Fractures	☐ Yes	Speech Problems	☐ Yes
Cardiac	☐ Yes	Gallbladder Problems	☐ Yes	Strokes	☐ Yes
Conditions	☐ Yes	Headaches	☐ Yes	Thyroid Disease	☐ Yes
Cardiac Pacemaker	☐ Yes	Hearing Impairment	☐ Yes	Tulierculosis	☐ Yes
Chemical	☐ Yes	Hepatitis	☐ Yes	Vision Problems	☐ Yes
Dependency	☐ Yes	High/Low Blood Pressure	☐ Yes		
Circulation Problems	☐ Yes	Incontinence	☐ Yes		

Past Surgical History:

Height: _____ Weight: _____ BMI: _____

1. _____
2. _____
3. _____

Current Medication List:

Drug Name Dosage Route (Orally, Injection, Other)

1. _____
2. _____
3. _____
4. _____
5. _____

Fall History:

Any falls in the last 12 months? Yes _____ No _____

If yes, how many? _____ Any injury from the fall? Yes _____ No _____

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Attention: _____ Fax: (_____) _____ - _____

PROTECTED HEALTH INFORMATION RELEASE

Full name:_____ Date of Birth:_____ SS#_____

This will authorize _____ Fax#: (_____) _____ - _____

to disclose my protected health information, as described below to:

Low Country Physical Therapy (Garden City)
2586 Hwy 17 Business South
Garden City, SC 29576
Tel: (843)651-6565 Fax: (843)651-6575

_____ Complete Medical Record

_____ Specific Information Only (list)

_____

Low Country Physical Therapy (Pawleys Island)
267 Willbrook Blvd. Suite D
Pawleys Island, SC 29585
Tel: (843)314-3980 Fax: (843) 314-3979

_____ other (describe)

_____

_____

Dates of care included: From _____ to _____

I understand that I may inspect or copy the protected health information described by this authorization. I understand that this authorization may be revoked in writing by me and delivered to the Privacy Contact of your organization at any time, although revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may be subject to federal or state law protecting its confidentiality. ·

Date: _____

Patient Signature or Authorized Representative:_____

Relationship to Patient:_____

EXPIRATION DATE: This authorization will expire on (date or event)_____/_____/_____(If no date or event is stated, expiration is six (6) months from the date signed).

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Low Country Physical Therapy Financial Policies and Procedures

Low Country Physical Therapy will collect $ _____.____ for your Initial Evaluation, and $____.____ for my all of my follow up visits. This is only an estimate and not the total cost of each visit.

The total cost of each visit will be determined once your insurance(s) processes your claims. This estimated amount will be applied towards your:

Co-Insurance of _____% Co-Pay of $ _____
Out of Pocket of $ _____ Deductible of $ _____

I certify the insurance information furnished by me is correct and hereby direct and authorize payment of healthcare benefits due for me by insurer to Low Country Physical Therapy. I understand I am financially responsible for payment of fees regardless of insurance coverage. Yes No

Low Country Physical Therapy will bill me monthly the difference of any additional co-insurance, deductible, and or missed co-pay(s) after all insurance(s) has processed, with the understanding payment is due when billed. If for any reason I over pay Low Country Physical Therapy a refund check will be issued once all insurance(s) has completely processed for every visit.

The above description is an estimate of my insurance(s) benefits. Low Country Physical Therapy assumes no liability for any errors made by my insurance carrier(s) in this quotation/estimation. It is my responsibility to clarify any discrepancies in eligibility and benefits and or authorization and inform Low Country Physical Therapy immediately. Low Country Physical Therapy cannot determine exactly what my insurance company allows until insurance processes based on my contract with my insurance carrier. I am responsible for all charges incurred, regardless of payment by my insurance company; any balance(s) due/charges not paid by my insurance company become my responsibility. If no payment is made on my account it will be forwarded to collections.

I have read and understand Low Country Physical Therapy's estimated billing and collection policies. I further understand I may obtain a copy of this policy upon my request, along with a copy of my Benefit Verification Form which contains specific details of my personal physical therapy benefits which were quoted from my insurance carrier to Low Country Physical Therapy. Yes No

Patient Name: _____Date: _____/_____/_____

Patient Signature: _____ _____Date: _____/_____/_____