



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

"We treat you like family"

2586 South Hwy 17 Business/ Garden City Beach, SC 29576/Tel (843)651-6565/Fax (843)651-6575
267 Willbrook Blvd, Suite D/Pawleys Island, SC 29585/Tel (843)314-3980/ Fax (843)314-3979

www.lowcountrypt.com • lowcountrypt@sc.rr.com

revised 10.1.19



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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 Business 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 Business or Ocean Highway. Turn right onto Willowbrook 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 E-mail *

*By giving my e-mail address, I agree to receive appointment reminders and any business updates from LCPT

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, Speech Therapy, Chiropractic and/or any type of Massage 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, Chiropractic and/or any type of Massage Therapy services since the first of the year? Yes No If yes, circle all that apply: PT OT Speech Chiropractic Massage Therapy

Where did you receive therapy services? How many visits did you have?:

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 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 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

Patient Signature: _____ Date: ____/____/____

Date: ____/____/____

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



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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

Have you received PT, OT, Speech Therapy, Chiropractic and/or any type of Massage Therapy services this year and or last year? Yes No

If Medicare, are you currently receiving Home Health Services? 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):

Office Use Only: Estim Code: <input type="checkbox"/> 97014 <input type="checkbox"/> G0283

(Please continue on reverse side)



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Past Medical History:

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

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

_____ Complete Medical Record
_____ Specific Information Only (list)

_____ 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: ____/____/____