SIGNATURE PHYSICAL THERAPY
Powered by APEXNETWORK

OFFICE ADMISSION FORM: PRIVATE OR MEDICARE

Called: _____ Appt. Day/Time: _____

PATIENT INFORMATION

Patient Name: _____

Email: _____ Facility: _____

Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Date of Birth: _____ Social Security Number: _____

Diagnosis: _____

Referring Physician: _____

Employment Status: _____ Marital Status: _____

Emergency Contact: _____ Phone Number: _____

Is treatment related to an accident? ☐ Yes ☐ No

If yes, what type of accident? Circle one: Employment Motor Vehicle Wrongful Injury

If the patient has Medicare, have they been involved in a Home Health Episode? ☐ Yes ☐ No

If yes, name and phone of Home Health Agency: _____

**Please obtain a discharge letter from the treating Home Health Agency before a patient begins treatment at Signature Physical Therapy.*

INSURANCE INFORMATION

Primary Insurance Company: _____ Phone: _____

Address: _____

City: _____ State: _____ ZIP: _____

ID #: _____ Group #: _____

Name of Insured (if different than patient): _____

Insured's Employer: _____

Secondary Insurance Company: _____ Phone: _____

Address: _____

City: _____ State: _____ ZIP: _____

ID #: _____ Group #: _____

Name of Insured (if different than patient): _____

Insured's Employer: _____

SIGNATURE MEDICAL GROUP

PATIENT REGISTRATION CONSENT & ACKNOWLEDGMENTS

CONSENT TO TREAT

I consent to Signature Medical Group (SMG) physicians, practitioners, and other providers ("Provider"), their assistants and staff to provide medical and/or surgical treatment, testing, supplies, medications, services, equipment and other items deemed necessary for the patient named below. I have been informed of the nature and purpose of the proposed treatment, common side effects, risks, benefits, alternatives and estimated duration of treatment as applicable. I understand that I may withdraw consent to treatment and will inform the attending Provider of any decision to terminate treatment. I agree to provide at least 24 hours notice prior to cancelling an appointment and understand that failure to provide notice may result in a cancellation fee. In the event of an emergency while receiving care at SMG, I authorize SMG staff to arrange for care and treatment necessary to address the emergency medical condition.

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY

I acknowledge that the patient or guarantor signing below is financially responsible for all charges for medical services provided by SMG and payment is due on the date of service. If an insurance/health plan claim is filed by SMG, I request that payment of all benefits be made directly to SMG. I agree to pay for any services or out-of-pocket expenses which are not covered by insurance. I acknowledge receipt and acceptance of SMG's Payment Policies provided with this form. I acknowledge that I will be responsible for payment of legal and collection fees in addition to the outstanding balance should SMG refer my account to an outside agency for collection.

RELEASE OF INFORMATION/DISCLOSURE OF PROTECTED HEALTH INFORMATION

I consent to SMG's release of the patient's protected health information (PHI) for treatment, payment and operations purposes in accordance with HIPAA. I acknowledge that SMG may release medical records and PHI to the third-party health plan or payer, including Medicare, Medicaid, health insurer, HMO, or other company or program that arranges or pays for the cost of some or all of the patient's health care. SMG may also release PHI to other health care providers involved in treating the patient including physicians, hospitals, laboratories, pharmacies and others. I have been provided with SMG's Notice of Privacy Practices that further describes the uses and disclosures of certain PHI by SMG. To facilitate treatment or payment, including communication of appointment reminders, prescriptions/refills, laboratory results and other information, I consent to SMG sharing PHI with the following individuals:

Name:_____ Relationship:_____ Phone Number:_____
Name:_____ Relationship:_____ Phone Number:_____
Name:_____ Relationship:_____ Phone Number:_____

Initial all applicable information:

_____Medical/Treatment/PHI including retrieval of medical records and prescription refills
_____Lab/Ancillary Testing/Radiology/MRI/Imaging Results
_____Billing/Insurance Information
_____Authorized to leave message on voice mail or by other designated communication systems
_____Other, Describe_____

ADVANCE DIRECTIVES FOR HEALTH CARE *(Living Will/Healthcare Directive, Durable Power of Attorney for Healthcare)*

(If applicable to the practice setting, patient to initial appropriate statement):

_____The patient does NOT have an Advance Directive

_____The patient has the following Advance Directive(s): _____
_____
and will provide a copy to the attending SMG physician practice

****

_____
Print Patient's Full Name *Patient Date of Birth*

_____ _____
Print Name of Guarantor/Legal Representative *Relationship to Patient*

_____ _____
Signature & Date Signed *Witness to Signature if applicable*

PAYMENT POLICIES
SIGNATURE MEDICAL GROUP

We accept cash, check, debit, Visa, MasterCard and most health plans/insurance programs. You may consent to automated payment card payments by signing a separate authorization.

If the patient is covered by insurance, the following apply:

1. **The patient/responsible party or guarantor signing below ("you") must provide us with the patient's current and correct medical coverage/insurance/health plan ("health plan") or other responsible third-party payor.**
2. **You must follow the rules of the health plan such as providing a valid referral form and precertification of testing and/or surgery when required by the health plan for payment. We will assist with this process, but if claims are denied because of your failure to comply with coverage/payment rules, you will be responsible for paying the denied claim(s).**
3. **You are responsible for paying any deductibles, co-payments, non-covered services or other costs not covered by the health plan.**
4. **Co-payments, non-covered services and other point of service payments must be paid at the time of service including amounts due for a child regardless of parental custody, divorce or separation terms.**
5. **WORK RELATED INJURIES:**
    a. **If the patient's employer has approved treatment, you will not be charged or billed.**
    b. **If the patient's employer does not approve treatment and <u>YOU SELECT US FOR YOUR TREATMENT</u>, you may be billed and you may be responsible for payment of services not approved by the employer.**
6. **If the patient is involved in a claim or lawsuit that affects the payment of our services, we hold you responsible for payment of our regular fees.**
7. **We file group health plan claims and by law, must file Medicare claims.**
8. **If you think your bill contains an error or if you need more information about an item on your bill, contact us at the address or telephone number on your bill.**

We expect payment in full at time of service for all charges which are not covered by the patient's health plan. It is your responsibility to contact us in the event of a need for an alternative payment plan or to apply for a discount if you do not have insurance.

In the event of non-payment, you will be responsible for any legal and collections fees. Legal and collection fees will be added to the outstanding balance on the account should the account be referred to an outside agency for collection.

I have read and agree to the above terms and hereby assume full responsibility for paying any medical service charges and collection fees according to these terms.

Print Patient Name: _____/Date of Birth: _____

Print Guarantor Name & Relationship to Patient: _____

Signed: _____/Date: _____
Patient or Guarantor/Responsible Party, if other than Patient

(Witness to Signature, if applicable): _____

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DISCLOSURE OF FINANCIAL INTEREST

Missouri state law, 334.100(22), RSMo, requires a physician notify the patient or guardian that the physician has a pecuniary (financial) interest in the physical therapy facility in which prescribed treatment is provided, and that physical therapy or rehabilitation services are available to the patient on a competitive basis from other facilities.

Therefore, I understand that the following physicians and doctor of podiatric medicine have a financial interest in the Signature Physical Therapy facility:

William Behrens, MD
Nathan M. Fisher, DO
Brian A. Fissel, MD
Alex Heck, MD
Ashok Kumar, MD
Coles E. L'Hommedieu, MD
Robert G. Medler, MD
Nathanael S. Olson, DO
Christopher W. Palmer, DO
Sri Pinnamaneni, MD
Patrick J. Reardon, MD
Robert H. Sigmund, MD
Kenneth S. "Buck" Smith, MD
Qasim Zaidi, MD
Amy M. Zippay, MD

Furthermore, I understand that I have the right to choose any other physical therapy or rehabilitation services which may be more convenient or competitive.

_____
Patient/Guardian Signature

_____
Date

Physical Therapy Providers located within 10 miles of
Signature Orthopedics South County

Advanced Training and Rehab	1391 Smizer Mill Road	Fenton, MO 63026
Advanced Training and Rehab	333 South Kirkwood Road	Kirkwood, MO 63122
Advanced Training and Rehab	3860 Vogel Road	Arnold, MO 63010
Advanced Training and Rehab	4020 Butler Hill Road	St. Louis, MO 63129
Advanced Training and Rehab	9560 Watson Road	Crestwood, MO 63126
ApexNetwork	2705 Dougherty Ferry Road	Kirkwood, MO 63122
ApexNetwork	524 Old Smizer Mill Road	Fenton, MO 63026
ApexNetwork	4500 Telegraph Road	St. Louis, MO 63129
ApexNetwork	8567 Watson Road	St. Louis, MO 63119
ApexNetwork	4590 South Lindbergh Blvd	Sunset Hills, MO 63127
Athletico	107 Concord Plaza	St. Louis, MO 63128
Athletico	2200 Barrett Station Road	St. Louis, MO 63021
Athletico	3156 Telegraph Road	St. Louis, MO 63125
Athletico	4337 Butler Hill Road, Suite L	St. Louis, MO 63129
Athletico	784 Gravois Bluff	Fenton, MO 63026
Athletico	3950 Vogel Road	Arnold, MO 63010
ATI Physical Therapy	4418 Telegraph Road	St. Louis, MO 63129
Axes Physical Therapy	4131 Union Road	St. Louis, MO 63129
Axes Physical Therapy	8015 MacKenzie Road	St. Louis, MO 63123
Axes Physical Therapy	118 Richardson Crossing	Arnold, MO 63010
Axes Physical Therapy	53 Fenton Plaza	Fenton, MO 63026
Cora Physical Therapy	11735 Manchester Road	St. Louis, MO 63131
Cora Physical Therapy	12626 Lamplighter Square	St. Louis, MO 63128
Cora Physical Therapy	160 Richardson Crossing	Arnold, MO 63010
Core Services	7508 Big Bend Boulevard	St. Louis, MO 63119
Crestwood Sport and Spine	8790 Watson Road	St. Louis, MO 63119
Excel Sports and Physical Therapy	9523 Gravois Avenue	St. Louis, MO 63123
Factor Physical Therapy	8031 Watson Road	St. Louis, MO 63119
HouseFit	3809 Lemay Ferry Road	St. Louis, MO 63128
Legacy Physical Therapy	2961 Dougherty Ferry Road	Kirkwood, MO 63122
Mercy Physical Therapy	10024 Watson Road	Crestwood, MO 63126
Mercy Physical Therapy	13303 Tesson Ferry Road	St. Louis, MO 63128
Mercy Physical Therapy	12700 Southfork Road	St. Louis, MO 63128
Mercy Physical Therapy	9964 Kennerly Road	St. Louis, MO 63128
Omni Physical Therapy	13314 Manchester Road	Des Peres, MO 63131
Peak Sport and Spine	9901 Watson Road	St. Louis, MO 63119
Signature Physical Therapy	12639 Old Tesson Road	St. Louis, MO 63128
Sports Medicine and Training	119 Watson Road	Crestwood, MO 63126
Sports Therapy and Rehabilitation Center	5201 MidAmerica Plaza	St. Louis, MO 63129
SSM Physical Therapy	1001 South Kirkwood Road	Kirkwood, MO 63122
SSM Physical Therapy	3920 Vogel Road	Arnold, MO 63010
SSM Physical Therapy	4 Arnold Park Mall	Arnold, MO 63010
SSM Physical Therapy	912 Meramec Station Road	Valley Park, MO 63088
SSM Physical Therapy	1011 Bowles Avenue	Fenton, MO 63026
SSM Physical Therapy	1050 Old Des Peres Road	St. Louis, MO 63131
SSM Physical Therapy	11135 Manchester Road	Kirkwood, MO 63122
SSM Physical Therapy	12900 Tesson Ferry Road	St. Louis, MO 63128
SSM Physical Therapy	6060 Telegraph Rd	St Louis, MO 63129
SSM Physical Therapy	201 South Kirkwood Road	St. Louis, MO 63122
SSM Physical Therapy	2532 Lemay Ferry Road	St. Louis, MO 63125
SSM Physical Therapy	29 Ronnies Plaza	St. Louis, MO 63126
SSM Physical Therapy	32 Hampton Village Plaza	St. Louis, MO 63109
SSM Physical Therapy	6555 Chippewa	St. Louis, MO 63109
SSM Physical Therapy	7391 Watson Road	St. Louis, MO 63119
SSM Physical Therapy	8654 Big Bend Boulevard	St. Louis, MO 63119
St. Louis Home Health	1000 Camera Avenue	Crestwood, MO 63126
Telegraph Road Physical Therapy	2909 Telegraph Road	St. Louis, MO 63125
The Physical Therapy Center	12048 Tesson Ferry Road	St. Louis, MO 63128

The Missouri Division of Professional Registration maintains a current list of Missouri licensed physical therapy providers. County or name searches can be performed at https://pr.mo.gov/licensee-search-division.asp.

The American Physical Therapy Association maintains a database of its members. Zip code and city searches can be performed at https://aptaapps.apta.org/APTAPTDirectory/FindAPTDirectory.aspx.

Updated 12/2023

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PATIENT HEALTH HISTORY

Patient Name: _____

Date of Birth: _____ Date of Appointment: _____

Height: _____ Weight: _____ MD Follow-up Date: _____

Reason for coming to therapy today: _____

Date of injury/When problem began: _____

How did the problem start? ☐ Lifting ☐ Twisting ☐ Falling ☐ Bending ☐ Motor Vehicle Accident

Describe: _____

What types of hobbies/activities/exercises did you regularly perform prior to your injury and how often? _____

_____

Have you had any diagnostic tests such as X-rays, MRIs, CT scans, etc.? If yes, please list: _____

_____

Pain at **LOWEST**: Rate your lowest pain level in the past week. 0 = no pain, 10 = worst pain imaginable.

_____

0 1 2 3 4 5 6 7 8 9 10

Pain at **WORST**: Rate your highest pain level in the past week.

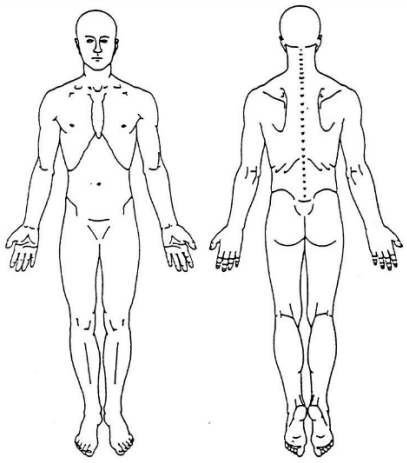
_____

0 1 2 3 4 5 6 7 8 9 10

Pain **CURRENTLY**: Rate your level of pain at this time.

_____

0 1 2 3 4 5 6 7 8 9 10



What makes your pain better? _____ What makes your pain worse? _____

Where have you have seen a decline in your abilities with your most recent condition? Circle all that apply.

Working	Lifting	Kneeling	Sleeping/resting	Dressing/grooming
Sitting	Carrying	Gripping	Getting in/out of bed	Balance
Standing	Bending	Turning head/trunk	Lying down	Exercise routine
Walking	Squatting	Driving	Rising from sitting	Other: _____

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PATIENT HEALTH HISTORY

Does your past medical history include any of the following? Circle all that apply.

Cardiac problems	Spinal/brain injury	Drug dependency	Osteoarthritis	Cancer
Fibromyalgia	Pacemaker	Alcohol dependency	Asthma	Rheumatoid arthritis
Seizures	High blood pressure	Open wound	Multiple sclerosis	Orthopedic problems
GI problems	Diabetes	COPD	Infectious disease	Muscular dystrophy
Parkinson's disease	Depression	Bowel incontinence	Lung disease	Autoimmune disease
Stroke/TIA	Kidney problems	Urinary incontinence	Pelvic pain	Concussion

Are you currently pregnant? ☐ Yes ☐ No

Have you had two or more falls within the past year? ☐ Yes ☐ No

Have you had one fall resulting in injury within the past year? ☐ Yes ☐ No

Have you used tobacco (smoke or smokeless) in the past year? ☐ Yes ☐ No

Please list any major surgeries with dates: _____

_____

Please list allergies (medications, latex, etc.): _____

_____

Please list all medications you are currently taking: _____

_____

What are your goals for therapy? _____

_____

_____

Patient Signature: _____ **Date:** _____