Donna P. Johnson
Physical Therapy PC

Over 25 years of providing patient focused care
www.DonnaJohnsonPT.com

28 Fourth Street
Fair Haven, VT 05743
Phone: 802-265-4055
Fax: 802-265-8838

153 Main Street, Suite 2
Poultney, VT 05764
Phone: 802-884-8213
Fax: 802-884-8214

If using worker's compensation or no-fault/auto insurance please have the following information available when calling to schedule:

Have you seen us before: ☐ YES ☐ NO

Patient name: _____ DOB: _____ Phone#: _____

Address: _____

Email address: _____

Emergency contact name: _____ Phone#: _____

Date of injury/accident: _____ Location: _____

Any physical therapy in your home: ☐ YES ☐ NO

Injury area: _____

Referring Dr: _____ PCP: _____

Employer: _____ Phone#: _____

Employer address: _____

Worker's Compensation/Auto Insurance Name: _____

Claims mailing address: _____

Claim#: _____

Case manager/Adjuster: _____

Phone#: _____ Fax#: _____

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Name: _____Date: _____

Please list two people we can contact for you in an emergency.

1. Name: _____ Telephone: _____

2. Name: _____ Telephone: _____

Please read this section carefully.

Have you received ANY care in your home this year? _____

Have you received any physical, occupational or speech therapy this year? _____

Are you currently being seen by one of the following:
☐ Chiropractor ☐ Massage therapist ☐ Acupuncturist ☐ Other:_____

Please check if you have had any of these conditions now or in the past.

Past	Present		Past	Present	
☐	☐	high blood pressure	☐	☐	pregnancy
☐	☐	angina	☐	☐	cancer
			Location:_____ Date: _____		
☐	☐	heart attack	☐	☐	tumor
☐	☐	shortness of breath	☐	☐	tobacco use
☐	☐	stroke	☐	☐	drug/alcohol dependence
☐	☐	asthma	☐	☐	headaches
☐	☐	HIV/AIDS	☐	☐	night pain
☐	☐	rheumatoid arthritis	☐	☐	osteoporosis
☐	☐	arthritis	☐	☐	skin condition
☐	☐	systemic lupus	☐	☐	dermatitis/rash
☐	☐	hepatitis	☐	☐	diabetes
☐	☐	epilepsy	☐	☐	other: _____

List of medications

We can copy your list of medications or you may list them below. If you cannot recall the medication name, write down the condition that it is used to treat. Your therapist will review this with you.

_____

_____

Medicare requirement: Height _____ Weight _____

Signature: _____Date: _____

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Patient Authorization Record – Worker's Compensation, Auto and No-Fault Insurance

Provider is 'Donna P Johnson Physical PC' (hereinafter referred to as "Provider"), 'Worker's Compensation', and 'Auto and No-fault Insurance' (hereinafter 'WC' and 'auto coverage')

Initial below

	Authorization for treatment • I hereby give authorization for the performance of such rehabilitation procedures as permitted by NY and VT statutes that are, in the judgment of my therapist, deemed necessary.
	Authorization for Release of Information • I agree that provider may provide information from my medical records to persons involved in my medical care. • I agree that provider may provide information and/or obtain information from others who have provided medical care to me and /or are responsible for the payment of all or part of my bills when this information is needed in order to treat, bill, and/or receive payment for services rendered.
	Verification and Authorization • I agree that the information given to provider in applying for benefits is complete and Accurate. • Provider with the information you provided, will request authorization for your treatment (to begin or continue your treatment). **Authorization does not guarantee payment.** • I understand rules governing coverage are set by state. Provider is not party to that contract. • I understand that provider, generally, will NOT submit bills to attorneys for payment of care provided. • In the event that my claim is denied by WC or auto coverage, or benefits are exhausted, I agree I am responsible to pay provider charges for services rendered to me during my course of treatment. If I do not pay for charges that are my responsibility, I agree to pay provider any collections fees incurred. • I understand that if my benefits are denied or exhausted, that I may request provider bill my personal insurance however payment for services remains my responsibility. Provider will only bill my personal insurance upon notification of denial from WC or your auto insurance carrier. Therefore we request information regarding your personal insurance carrier, including a copy of your current insurance card.
	Authorization for Release of Payment • I authorize that direct payment of any benefits available to me be released to Donna P Johnson Physical Therapy PC for services rendered.

Patient signature or signature of legal representative/POA Date

Printed patient name Date

Revised 11-22-2016