Email Request Form

Boulet Physical Therapy and Wellness Institute, requests your email address in order to provide you with important medical and physical therapy information on a timely basis.

We assure you that we will NOT share your email address with any 3rd party.

Please complete the information below and return it to one of our office members.

Primary Email Address

Secondary Email Address

Patient's name (please print)

Patient's Signature

_____

Date

Patient Information Form

Name: _____ *Hm Phone:* _____ *Wk Phone:* _____

Home Address: _____ *City:* _____ *Zip Code:* _____

Spouse's Name: _____ *Wk Phone:* _____

*Cell Phone:*_____ *Spouse's Cell Phone:*_____

Nearest Relative not living with you: _____ *Phone:* _____

Nearest friend not living with you: _____ *Phone:* _____

Referring Physician: _____ *Phone:* _____

*Primary Physician:*_____*Phone:* _____

Dentist: _____ *Phone:* _____

Place of Employment: _____ *Phone:*_____*Occupation:*_____

*Address:*_____*City*_____*State*___*Zip Code*_____

Social Security #: _____ *Date of Birth:* _____

Whom may we contact in the case of an emergency?

_____ *Phone:* _____

Whom may we thank for referring you to us?

_____ *Phone:* _____

Who is responsible for this bill? _____

I will be paying today by cash: ____*check:* ____ *credit card:* _____

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

_____ _____

Signature *Date*

_____ _____

Parent (if minor) *Date*

Boulet Physical Therapy and Wellness Institute
119 Representative Row
Lafayette, LA 70508

Insurance Information

Patient Name:_____ Name of Primary Insured:_____

Primary Insured DOB:_____Primary Insured Employer:_____

Primary Insured Occupation:_____ Group #:_____

SS#/Contract ID #:_____

I hereby instruct and direct _____Insurance Company/Attorney to pay by check made out and mailed to:

Boulet Physical Therapy and Wellness Institute

Or

If my current policy prohibits direct payment of Boulet Physical Therapy and Wellness Institute, I hereby also instruct and direct you to make out the check to me and mail it as follows:

C/O Boulet Physical Therapy and Wellness Institute
P O Box 80764
Lafayette, LA 70598-0764

For the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize Boulet Physical Therapy and Wellness Institute to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Date:_____

Patient Signature:_____ Witness:_____

Please Print Name:_____

BOULET PHYSICAL THERAPY AND WELLNESS INSTITUTE

FINANCIAL POLICY AND PROCEDURES

We are committed to providing you with the best possible care. If you have health insurance we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment for services is due at the time services are rendered. We accept cash, checks, MasterCard, Visa or Discover. We will be happy to file your insurance claim-form for you for insurance reimbursement.

*Returned checks and balances older than 30 days may be subject to additional collection fees and interest charges of **1 ½%** per month. We require a 24-hour cancellation notice if you are unable to keep your scheduled appointment. If you fail to cancel your appointment within 24 hours of your scheduled time we will collect a $25.00 fee prior to you receiving any additional physical therapy treatment.*

We will turn your account over to a collection agency if your bill is not paid in full within 90 days of your discharge date.

If an attorney is representing you, you will pay for depositions, court testimonies, attorney meetings and any and all legal matters in the event your attorney fails to make payment.

I have received a copy and fully understand Boulet Physical Therapy and Wellness Institute's Financial Policy and Notice of Patient Information Practices. I understand that BPTWI may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed. I understand that I retain the right to revoke this consent if I notify BPTWI in writing. I also understand that BPTWI will consider request for restriction on a case-by-case basis, but does not have to agree to the request for restrictions.

_____ _____

Patient Signature *Date*

_____ _____

Reviewed By *Date*

Boulet Physical Therapy and Wellness Institute
NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

Boulet Physical Therapy and Wellness Institute's LEGAL DUTY

BPTWI is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

BPTWI uses your personal health information primarily for treatment, obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For Example: BPTWI may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

BPTWI may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, BPTWI's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

BPTWI may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. BPTWI will consider all such requests on a case-by-case basis, but BPTWI is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that BPTWI may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on BPTWI's health information practices, or if you have a complaint, please contact the following person:

Christine Hebert, Office Administrator
Boulet Physical Therapy and Wellness Institute
119 Representative Row
Lafayette, LA 70508
Telephone: (337) 264-9856 Fax: (337) 261-5042

BOULET PHYSICAL THERAPY AND WELLNESS INSTITUTE

119 Representative Row
Lafayette, LA 70508
Phone: (337) 264-9856 Fax: (337) 261-5042

PERTINENT MEDICAL HISTORY

Name:_____ Therapist:_____

Do you have a history of:	**Yes**	**No**	**COMMENTS:**
High Blood Pressure	◯	◯	
Stroke	◯	◯	
Heart Disease	◯	◯	
Osteoporosis Do you take: (circle) Fosamax? ☐ Actonel? ☐ Boniva? ☐ Reclast? ☐	◯	◯	
Arthritis	◯	◯	
Diabetes	◯	◯	
Bowel/Bladder Problems	◯	◯	
Respiratory Problems	◯	◯	
Long term use of corticosteroids	◯	◯	
Recent/unexplained weight gain/loss	◯	◯	
Nausea/ dizziness	◯	◯	
Cancer	◯	◯	
Other Conditions/injuries	◯	◯	

Do you have:	**Yes**	**No**	**COMMENTS**:
Pacemaker?	◯	◯	
Metal implants?	◯	◯	
Are you pregnant?	◯	◯	

Please List:

SURGERIES:_____

MEDICATIONS: **Do you take Calcium Supplements**? ◯Yes ◯No **Do you take Vitamin D3**? ◯Yes ◯No

MEDICATIONS: _____

_____

Reviewed by Physical Therapist ☐Yes ☐No

PREVIOUS TREATMENT FOR THIS CONDITION:_____

PATIENT SIGNATURE:_____Date:_____