Indigo Therapy Specialists
A CORA Physical Therapy Clinic

PATIENT HISTORY SHEET

Date:____/____/_____

PATIENT INFORMATION

Name: **Height:** **Weight:**

Address:

Home: **Mobile:** **Work:**

Date of Birth: **SS#:** **Email:**

I consent to receiving text message, email and/or phone reminders, and understand I can opt out at any time.
□ Do not send text reminders □ Do not send emails

How did you hear about Indigo? □ Self □ Friend/Family □ Doctor □ Employer □ Event □ Google □ Website □ Facebook □ Other

Name/Title of person who referred you: **Phone:**

Primary Care Physican: **Phone:**

Emergency Contact/ Relationship:

Home: **Mobile:** **Work:**

MEDICAL HISTORY

Do you have/had any of the following medical illnesses/concerns? Please circle YES (Y) or NO (N)

Heart Problems	Y	N	**Pregnant**	Y	N	**Smoke/Tobacco Products**	Y	N	**Seizures**	Y	N
High Blood Pressure	Y	N	**Diabetes**	Y	N	**Asthma**	Y	N	**HIV/AIDS**	Y	N
Pacemaker	Y	N	**Cancer**	Y	N	**Osteoporosis**	Y	N	**Stroke**	Y	N

List all current medications, and include amount/frequency (i.e. Darvocet, 100 mg, every 6 hours):

Do you have any allergies? *If yes, please list.*

Please describe your chief physical complaint and (i.e. back pain):

How/When it happened (i.e. lifted a box at work, two weeks ago):

Have you had previous therapy for this problem/injury? □ Yes □ No If yes, was it helpful? □ Yes □ No

What other surgeries/injuries have you had in the last five years?

WORK INFORMATION

Injury related to a work accident? □ Yes □ No *If yes, please complete this section.*

Employer name: Phone:

Address:

What is your regular job?

Present work status (circle):
Full-time/ Regular Part-time/Regular Full-time/Modified Part-time/Modified Not working Unemployed Retired

AUTO ACCIDENT INFORMATION

Injury related to an auto accident? □ Yes □ No *If yes, please complete this section.*

Auto insurance company:

Attorney name: Phone:

Do you have a letter of exhaustion from your auto carrier? □ Yes □ No Can you provide us with a copy? □ Yes □ No

Health insurance company: Phone:

Name of primary insured: ID number:

A 24-hour prior notification of all cancellations is required and appreciated so that the appointment time may be used for others in need of therapy. If two scheduled appointments are missed without reasonable cause, Indigo reserves the right to notify the referring physician's office and/or case manager/insurance company.

Patient Signature: _____

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Acknowledgement of Receipt of Notice of Privacy Practices and Release Authorization

I certify that I have received a copy of CORA South Carolina, LLC, dba Indigo Therapy Specialists ("Indigo") Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Indigo's health care operations. The Notice of Privacy Practices also describes my rights and Indigo's duties with respect to my protected health information. The Notice of Privacy Practices is also posted in the Front Desk area and on Indigo's website at www.corahealth.com.

Indigo reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, asking for one at the time of my next appointment or accessing Indigo's website.

By signing this Authorization Form, I understand that I am giving my authorization to Indigo's designated medical record custodians, database custodians, central billing / collections office personnel to use and/or disclose my protected health information (PHI), as described in more detail in the paragraphs below, to the following person(s) or organization(s):

Name of person(s) or organization(s): _____
Street address: _____
City, State, and zip code: _____
Telephone number: _____
Fax number: _____
Relationship to patient: _____

If this authorization is for any purpose other than the release of medical records for personal reasons, please state the purpose of the authorization to release PHI below:

_____

I may revoke this authorization at any time by notifying Indigo in writing to Attention Collections Manager, 1110 Shawnee Road, Lima, OH, 45805 of my intent to revoke this authorization. However, I also understand that such a revocation will not have any effect on any information already used or disclosed by Indigo before Indigo received my written notice of revocation. Unless earlier revoked, this authorization will expire on the 180th day of the signing (or as otherwise specified _____).

AUTHORIZATION CONSENT FOR CARE AND TREATMENT

I hereby give my consent to the facility and/or treating physicians and their agents to release all records, including via electronic transmittal, prepared in the course of my treatment, to any entity which provides financial assistance for my health care, including, but not limited to, insurance companies and their agents, self-insured employers or public welfare agencies. I certify that the information given by me in applying for payment under Title XVII of the social security act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and/or the Medicare program or its intermediaries or carriers, or to the professional standards review organizations any information needed for this or a related Medicare claim. I understand that by signing this form, records of a confidential nature, such as Social Security Numbers and those for HIV testing, AIDS or AIDS related condition, psychiatric problems or substance abuse, will be released to the entities providing financial assistance for my health care. This release includes disclosing data to local, state, federal, other entities for routine operational purpose of regulatory, legal or contract compliance, accreditation, peer review, quality improvement, continuity of care, or processing appeals for claims denials. I also understand that I may revoke this consent at any time and without revocation and that it will expire one year from this date, or if admitted, one year from the date of discharge. I acknowledge that I have been provided and given the opportunity to review the Facility's Information regarding patient's rights and responsibilities. I hereby authorize Indigo to provide care and treatment under my physician's direction or as allowed under my state's direct access provisions.

_____	_____	_____
Signature of Patient or Representative	**Name of Patient or Representative**	**Date**

_____
Witness

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FINANCIAL RESPONSIBILITY

I understand that my insurance contract is between me, my employer (if applicable) and the insurance carrier and that CORA South Carolina, LLC, dba Indigo Therapy Specialists ("Indigo") is not a party to that contract. I understand that, as a matter of process, Indigo will contact my insurance carrier (including Medicare) to verify my benefits and the services covered under my insurance contract. I acknowledge that providing accurate insurance and other information is critical to determining my eligibility under my insurance contract. I understand that Indigo is verifying benefits as a courtesy and that ultimately it is my responsibility to understand what is covered and required under my policy.

I understand that Indigo will bill my insurance carrier (including Medicare) for services rendered upon verification of coverage by my insurance carrier**. I understand that verification of benefits is not a guarantee of payment and my financial responsibility is subject to change.** If my insurance carrier fails to render payment for services rendered, I hereby personally guarantee payment for medical care and services rendered. If my insurance carrier does not remit payments, including if I am denied benefits under workers compensation, I understand that I will be responsible for the balance due in full.

I understand that I am responsible for paying my co-payments, co-insurance (including co-insurance from Medicare) and deductibles at the time of service which I acknowledge may be an estimate at that time. Further, I understand that federal and state laws and insurance carrier contracts prevent Indigo from adjusting, writing off or waiving co-payments, co-insurance (including co-insurance from Medicare) and deductibles. I also understand that I am responsible for any balance due after payment by my insurance carrier.

Pursuant to the assignment of benefits herein; I hereby request that my insurance carrier make payment directly to Indigo for all services rendered by this facility. If my current policy prohibits direct payment to Indigo, I hereby instruct and direct my insurance carrier to make the check out in my name but send the check to: Indigo, 1110 Shawnee Road, Lima, OH 45805. If my insurance carrier makes payments to me I agree to immediately pay over these funds to Indigo. I also authorize Indigo to deposit check received on my account when made out to me.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

ASSIGNMENT OF BENEFITS

I, the undersigned, hereby assign to Indigo (hereinafter "Assignee") any and all rights, claims, benefits, and causes of action for personal injury protection benefits and medical payment benefits available to me under the policy affording coverage to me for any and all treatment, services, and medical claims resulting from an automobile accident that occurred on _____. This is to act as an assignment of my rights and benefits to the extent of Assignee's services provided. In the event that I do not have insurance coverage, I understand that I remain personally responsible for payment of services rendered including all costs of collection, including attorney's fees and costs.

ASSIGNMENT OF CAUSE OF ACTION

I hereby assign by this instrument all rights and causes of action in tort, in contract and the laws of the state where I am being treated against the personal injury protection carrier, if any for its failure to pay for services rendered unto me by Assignee in relation to my accident that occurred on _____/_____/_____.

Please call our Billing Office if you have any questions on your account or if you are unable to pay your balance in full they will be able to discuss payment arrangements with you. The number is 866-493-9410.

VERIFICATION OF BENEFITS

Your primary health insurance carrier had verified that you have a $ _____yearly deductible of which $_____ has been met.
After your deductible has been satisfied, your insurance carrier **estimates** your therapeutic benefits are covered at _____%.
You have an **estimated** responsibility of $ _____ or %_____due at each visit.

Your insurance carrier has advised us that your policy has the following limitations:

_____
Print Name of Patient

_____ _____
Print Name of Guardian (if applicable) Relationship to Patient (if applicable)

_____ _____
Patient/Guardian Signature Witness

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MEDICARE PATIENTS ONLY
Medicare Outpatient Therapy Qualification

In order to determine your eligibility for outpatient therapy services please answer the following questions:

Is a Home Health Representative, Nurse, Aide, Therapist or anyone other than a family member currently assisting you in your home with:

-Physical, occupational or speech therapy: ☐ Yes ☐ No

-Wound care: ☐ Yes ☐ No

-Injections or medications: ☐ Yes ☐ No

-Bathing or personal care: ☐ Yes ☐ No

-IV care: ☐ Yes ☐ No

-Any services not listed above: ☐ Yes ☐ No

Has a Home Health Representative, Nurse, Aide, Therapist or anyone other than a family member assisted you in your home with services in the past 30 days: ☐ Yes ☐ No

If you answered **"YES"** to any of the questions above, you MAY NOT be eligible for outpatient therapy services as determined by Medicare's guidelines. In order to qualify for our services you will need to be discharged completely from all home care services, which is your responsibility. A copy of the Medicare ABN form provided for you to read and sign. You understand that if claims are denied you will be responsible for these charges.

_____ _____

Patient/Guardian Signature Date

To be completed by Front Desk

Did you contact the CBO to verify that patient was not covered under home health?
☐Yes ☐ No **attach email Discharge date _____

ABN Form: ☐ Yes ☐ No

_____

Signature of employee verifying discharge