

Please verify therapy benefits and FAX benefits information back to us @ 524-0965 Thanks,
Physical Therapy Registration Sheet CPSI Quick Registration # _____

MedAdept # _____

___ FAX to Registration 524-5326 (time of FAX: _____) () Miami athlete Trainer: _____
 (phone: 524-5416) () Miami student

() current/previous patient []PT []MHMH

Date: ___/___/___ () Ped. P.T.-Amy () O.T.(hand)-Linda () O.T.-Audra () Speech-Jeanne

1. Name		2. Date of Birth ___/___/___	
3. Home or cell phone (circle one)		4. Work phone or Parent's phone	
5. Referring Physician (first & last name) Primary Care Physician (first & last name)		6. Physician Street Address / Phone / FAX if not Oxford physician	
7. Race ()Black ()White ()Asian ()American Indian/Alaska Native ()Native Hawaiian/Pacific Islander ()Hispanic ()Multi-racial () Declined ()Unavailable		8. Spoken & Written Language () English () Spanish () Other () Declined () Unavailable	
9. Diagnosis		MRI location/phone #	
10. Onset date of diagnosis ___/___/___ month/day/year		11. Date of surgery ___/___/___ month/day/year	
12. Level of pain () 1 () 2 () 3 () 4 () 5 () 6 () 7 () 8 () 9 () 10		13. () constant () intermittent	
14. () Accident	15. () Injury	16. () Auto Accident 17. State of _____	18. () Other/Unknown
19. Work related? () yes () no		20. If work-related () Indiana () Ohio	
21. If W/C, name of MCO: () CareWorks () Comp Management () Shakely () Other = _____			
Name of Case Mgr. _____		Phone # _____	Claim # _____
If Ohio W/C: Do not schedule until Carolyn has verified W/C authorization and C-9. Referring physician obtains W/C authorization and C-9 and will FAX it to us (usually takes 5 working days). Carolyn will notify patient to call and schedule.			
22. Insurance (If Medicaid, list the full name of the plan) Health Alliance - we are not providers (the patient will have minimal out-of-network benefits if they come here) TriCare Prime requires PCP referral/authorization; place on-hold until PCP FAX's authorization letter to us We are not currently providers for Anthem Senior Advantage/ Humana PPO / Medicare Complete / EverCare			
Primary (specific insurance name and plan name)		Secondary (specific insurance name and plan name)	
If Medicare, is patient currently receiving homecare? [] No [] Yes If yes, do not schedule the patient. Give this form to Donna (to obtain written authorization to provide outpatient therapy). Donna to return this form to front desk to schedule the patient.			
Home Care			
Agency		Contact	Phone #
Miami Athlete? [] will use Miami Athletic Department insurance.			
Miami Student? [] will use Maskin (student insurance).			
23. ()Yes ()No Have you received physical therapy or chiropractic therapy within the last 12 months? (if yes, circle one/both) Treatment from elsewhere will count towards insurance benefits.			
If yes, where? _____	When? _____	Number of treatments received _____	
24. If Medicaid? () Indiana () Ohio			
25. Scheduled Note: Remind the patient to bring their driver's license or picture identification card for us to copy.			
Appointment Date	Appointment Time	Therapist	

[] MHMH not a provider (give the form to Donna).

[] Earlier appointment date offered to patient; patient preferred to wait.

[] Modified Barium Swallow (Jeanne) The call always comes from Central Scheduling (5555) - must allow 1 hr. 10am-2pm).

25. Home Address	
26. Marital Status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W	27. Patient's SS#
28. Patient's Employer	
29. Primary Card Holder (Name / DOB)	30. Employer of Primary Card Holder
31. Insurance a) Member ID _____ b) Group # _____	32. Insurance Mailing Address 33. Insurance Phone # _____
34. Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child	35. Emergency Contact Name: Phone #

35. Secondary Card Holder (Name / DOB)	36. Employer
37. Insurance a) Member ID _____ b) Group # _____	38. Insurance Mailing Address 39. Insurance Phone # _____