

# Oasis Therapy

## Patient Information Form

<b>Date of Call/Registration:</b> <b>Past Patient</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Patient Account Number:</b>		
<b>Patient Information</b> <span style="float: right;">verified DL/photo i.d.:   <input type="checkbox"/> Yes   <input type="checkbox"/> No</span>				
Last Name/Suffix		First Name	Middle Initial	
Address:		City	State:   Zip Code:	
Home Phone	Other Phone (Cell)		Email Address	
Date of Birth	SSN	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Unknown	
<b>Employer Information</b>				
Employer Name:		Employment Status: <input type="checkbox"/> None <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> Self-Emp. <input type="checkbox"/> Retired <input type="checkbox"/> Student		
Address:		City	State:   Zip Code:	
Work Phone Number		Patient Occupation		
<b>Emergency Contact Information</b>				
Contact Name:	Phone #	Relationship to Patient: <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Sibling <input type="checkbox"/> Other		
<b>Physician Information</b>				
Name of Referring Physician:		Telephone #:	RX Date: _____ Eval/Treat: <input type="checkbox"/> # of visits: _____	
<b>Additional Questions</b>				
Date of Injury Onset Date	Auto Related: <input type="checkbox"/> Yes-State? _____ <input type="checkbox"/> No  <b>Adjuster name:</b> _____ <b>Phone #:</b> _____	Work Related: <input type="checkbox"/> Yes <input type="checkbox"/> No	Accident Related: <input type="checkbox"/> Yes <input type="checkbox"/> No	Diagnosis/Body Part
Post Surgical: <input type="checkbox"/> Yes / <input type="checkbox"/> No / <input type="checkbox"/> Unknown		Surgery Description: _____		
Surgery Date (if applicable): _____				
Have you any prior Therapy this year? <input type="checkbox"/> Yes <input type="checkbox"/> No (PT/OT/SP or Chiropractic)		How did you hear about us?		
<b>MEDICARE ONLY- Additional Questions</b>				
If Medicare, are you currently receiving Home Health Service? <input type="checkbox"/> Yes <input type="checkbox"/> No   If yes, Name of Agency ? _____ If Yes, what type of Home Health Services are you receiving? _____ Last Date of Service _____				
If Medicare, have you received PT, OT or Speech services since the first of the year? <input type="checkbox"/> Yes <input type="checkbox"/> No <ul style="list-style-type: none"> <li>• If Yes, do you know if you have exceeded your Medicare Therapy Cap amount?   <input type="checkbox"/> Yes   <input type="checkbox"/> No</li> <li>• Are you aware of any partial amount used since the first of the year?   \$ _____.</li> <li>• If Yes, please bring in any billing information from your previous therapy, or contact your previous provider for the information. Please bring the Medicare benefit summary you receive from Medicare.</li> </ul>				
Appointment Date:		Time:	Therapist:	
<b>Intake Completed By:</b> _____ <b>Date:</b> _____		<b>Patient, Please initial here if the above information is complete and correct</b> _____ <b>Date:</b> _____		

Patient Name:

Account Number:

**Insurance Information****Primary****Secondary**

Last Name:	First Name:	Middle Initial	SSN	DOB
<b>Patient Relationship to Policy Holder:</b> <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		
Employer Name:		Employer Phone #:		
<b>Primary Insurance Section</b>		<b>Secondary Insurance Section</b>		
Payor/Plan		Payor/Plan		
Code:		Code:		
Policy/ID #:	Group #:	Policy/ID #:	Group #:	
Insurance Phone #:		Insurance Phone #:		

**All Information Below "FOR OFFICE USE ONLY"****Verification****AT:****FSC:**

Date:	Spoke with:	Date:	Spoke with:
Verify Plan: _____ Effective Date: _____	Verify Plan: _____ Effective Date: _____		
Is this a Federally Funded Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does patient have both PT and/or OT coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Informed Payor this is outpatient therapy performed in an office setting: <input type="checkbox"/>		Informed Payor this is outpatient therapy performed in an office setting: <input type="checkbox"/>	
Visit Limitation:	Coverage:	Visit Limitation:	Coverage:
Limitations on Modalities or Units? Home Program/97535 ___ Anodyne/97026 ___ Aquatic/97113 ___ Other / / Other / /		Limitations on Modalities or Units? Home Program/97535 ___ Anodyne/97026 ___ Aquatic/97113 ___ Other / / Other / /	
Comments/Special Instructions:		Comments/Special Instructions:	
Deductible: \$ Met: <input type="checkbox"/> Yes <input type="checkbox"/> No	Out Of Pocket: \$ Met: <input type="checkbox"/> Yes <input type="checkbox"/> No	Deductible: \$ Met: <input type="checkbox"/> Yes <input type="checkbox"/> No	Out Of Pocket: \$ Met: <input type="checkbox"/> Yes <input type="checkbox"/> No
Does patient have a co-pay? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, amount: \$ Per Visit? <input type="checkbox"/> IE/Re-eval only? <input type="checkbox"/>		Does patient have a co-pay? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, amount: \$ Per Visit? <input type="checkbox"/> IE/Re-eval only? <input type="checkbox"/>	
Required for therapy? <input type="checkbox"/> Referral <input type="checkbox"/> Authorization <input type="checkbox"/> Pre-Cert If any of the above is required, verify that it is on file? <input type="checkbox"/>		Required for therapy? <input type="checkbox"/> Referral <input type="checkbox"/> Authorization <input type="checkbox"/> Pre-Cert If any of the above is required, verify that it is on file? <input type="checkbox"/>	
Auth #: _____ # of Auth Visits: _____	Auth #: _____ # of Auth Visits: _____		
Auth Start Date: _____ Auth Exp Date: _____	Auth Start Date: _____ Auth Exp Date: _____		
Claims Address:		Claims Address:	

**Verification (Workers Compensation)**

Is this a State Funded <input type="checkbox"/> or Self Insured plan <input type="checkbox"/> (call employer)	Plan Name: _____
Claim Number: _____	Dx Codes on file: _____
<input type="checkbox"/> Allowed <input type="checkbox"/> In Process <input type="checkbox"/> Pending <input type="checkbox"/> Hearing <input type="checkbox"/> Other	
Adjuster Name: _____ Phone: _____ Fax: _____	
Nurse/Case Manager Name: _____ Phone: _____ Fax: _____	
Additional Notes:	

**Verified By:****Date:****Form#: 20170201**