PATIENT INFORMATION

Last Name: _____ (Jr., Sr., Etc.) Sex: M or F

First Name: _____ M: _____

Street Address: _____ Apt _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell: _____ Date of Birth: _____

Age: _____ Social Security #: _____

Driver's License # _____ State: _____

Marital Status: ☐ Married ☐Single ☐Other _____

Employer: _____Occupation: _____

Employer Address:

_____

RESPONSIBLE PARTY FOR PAYMENT:

_____

Address: _____City: _____

State: _____ Zip Code: _____

Phone: _____

Employer: _____

REFERRED BY: _____

Date of Injury: _____Part of Body being treated: _____

Date of Follow-Up Appointment with Referring Doctor: _____

Your Primary Care Physician: _____Phone: _____

On the Job Injury? ☐ YES ☐ NO X-Rays Taken? ☐ YES ☐ NO

☐ Right Handed ☐ Left Handed

Primary INS: _____ Insured Name DOB: _____

Worker's Comp Insurance Co. _____

Claim # _____ Auto Accident? ☐ YES ☐ NO

Do you have an Attorney pertaining to this injury? ☐ YES ☐ NO

If yes, Attorney's Name: _____

Attorney's Phone: _____

NEXT OF KIN INFORMATION

Name: _____ Phone: _____

Address: _____

Employer: _____Work Phone: _____

Cell: _____

PREVIOUS THERAPY INFORMATION

Have you received any other Therapy Services in this calendar year? ☐YES ☐ NO

Have you received or are you currently receiving Home Health Therapy? ☐ YES ☐ NO

If yes, please provide dates: _____

Have you or are you currently receiving Chiropractic treatment? ☐ YES ☐NO

I hereby authorize payment of medical benefits to _____, for services furnished me. I also authorize the therapists to release any information in the course of my examination or treatment. This assignment will remain in effect until revoked by me in writing. A photocopy is to be considered as valid as the original**. I HEREBY ACCEPT FINANCIAL RESPONSIBILITY FOR ALL CHANGES INCURRED WHETHER OR NOTH I HAVE INSURANCE COVERAGE. VERIFICATION OF BENEFITS WE RECEIVE FROM YOUR INSURANCE IS NOT A GUARANTEE OF PAYMENT**.

_____ _____

Patient's Signature of Responsible Party Signature Date

Patient Medical History

Name:_____ Referring Physician: _____

Date of Injury: _____

Date of next Doctors visit for Injury: _____

Have you had surgery for this injury: ☐ YES ☐ NO Date of Surgery: _____

Are you currently taking any prescriptions or non-prescription medication? ☐YES ☐ NO

Please list all medications you are currently taking, please include dosage:

_____

_____

_____

Do you now have or have you ever had ANY of the following?

	YES	NO		YES	NO
Asthma, Bronchitis, or Emphysema	☐	☐	Severe or frequent headaches	☐	☐
Shortness of breath/Chest pain	☐	☐	Vision or hearing difficulties	☐	☐
Coronary artery disease or Angina	☐	☐	Numbness or Tingling	☐	☐
Do you have a pacemaker?	☐	☐	Dizziness or fainting	☐	☐
High Blood Pressure	☐	☐	Bowel or Bladder Problems	☐	☐
Heart Attack or Surgery	☐	☐	Weakness	☐	☐
Stoke/TIA	☐	☐	Weight Loss/Energy Lo	☐	☐
Congestive Heart Disease	☐	☐	Hernia	☐	☐
Blood Clot/Emboli	☐	☐	Varicose Veins	☐	☐
Epilepsy	☐	☐	Allergies	☐	☐
Thyroid Disease or Goiter	☐	☐	Any Pins or Metal Implants	☐	☐
Anemia	☐	☐	Joint Replacement Surgery	☐	☐
Infectious Disease	☐	☐	Neck Injury/Surgery	☐	☐
Diabetes	☐	☐	Shoulder Injury/Surgery	☐	☐
Cancer or Chemotherapy	☐	☐	Elbow/Hand Injury/Surgery	☐	☐
Arthritis	☐	☐	Back Injury/Surgery	☐	☐
Osteoporosis	☐	☐	Knee Injury/Surgery	☐	☐
Gout	☐	☐	Leg/Ankle/Foot Injury/Surgery	☐	☐
Sleeping Problems/Difficulties	☐	☐	Are you pregnant?	☐	☐
Emotional/Psychological Problems	☐	☐	Do you use Tobacco?	☐	☐

If yes, how long have you used tobacco? _____

How often do you use tobacco? _____

List any other information that would assist us in your care:

_____
_____
_____
_____

What are your rehabilitation expectations/goals while in this program?

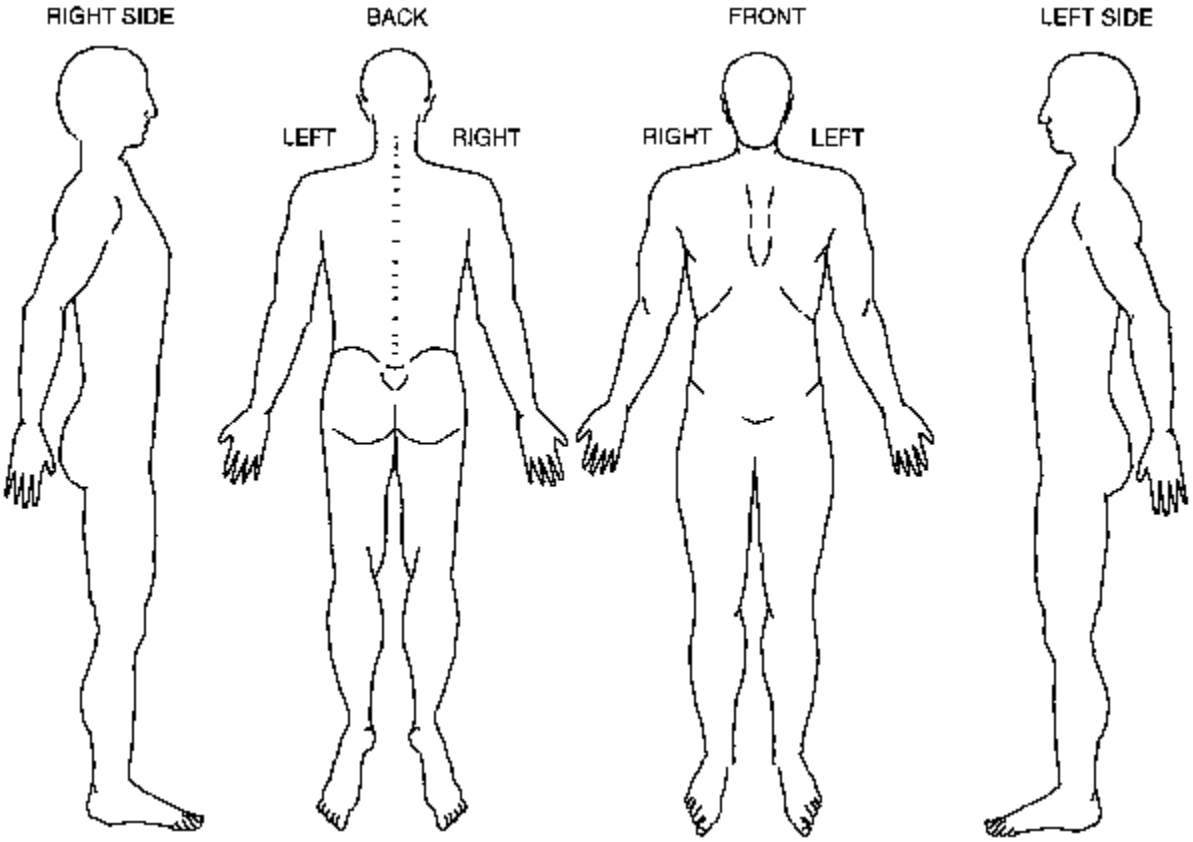
_____
_____
_____
_____

_____ _____

Patient/Guardian Signature Date

Patient Pain Assessment

Please indicate where your pain is located using the picture below



Please use the scale below to answer the following questions

NO PAIN AT ALL 0 1 2 3 4 5 6 7 8 9 10 WORST POSSIBLE PAIN

Please rate your current pain level: ____ Your pain at its worst: _____ Your pain at its best ____

Please describe your pain (e.g. sharp, shooting, and stabbing): _____

Please describe the frequency of your pain (e.g. constant, intermittent): _____

Please tell us what relieves your pain (e.g. rest, medication): _____

Please tell us what makes your pain worse (e.g. lifting, sitting, and bending): _____

_____ _____

Patient Signature Date Therapist Signature Date

FINANCIAL POLICY & ASSIGNMENT OF BENEFITS

All fees for medical care are based in the usual, reasonable and customary fee charged in this area by physical therapists of equal training and experience.

PAYMENT FOR MEDICAL SERVICES RENDERED ARE DUE AT THE TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE. **You will be expected to pay your insurance co-payment at each visit.** There will be a $25 service charge for any checks returned to our office.

Our office will make every effort to verify eligibility and benefits with your health insurance company. **The amount quoted to use over the telephone is NOT a guarantee of payment or determination of benefits. It is an estimated amount that you are responsible for. It is ultimately your responsibility to know the type of insurance plan/policy you are enrolled in and whether we are contracted providers.** The exception is for those patients with work-related claims covered by Worker's Compensation. These patients are not responsible for their bills unless their claim has been denied.

Having read the above, I hereby authorize payment by my insurance carrier or other designated payor of medical benefits to _____ for services furnished to me. This assignment will remain in effect until revoked by me in writing. I hereby accept financial responsibility for all charges incurred whether I have insurance coverage. I understand that _____ requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. **I further understand and agree that if the account is not paid within 90 days of the last date of service and no financial arrangements have been made, I will be personally responsible for any and all expenses incurred in the pursuit of collection of my account including and all attorney's fees, fining fees, including charges or commissions that may be assessed by any collection agency retained to pursue this matter and interest at the legal rate plus 2% over prime.**

I also authorize _____ to release to my insurance carrier or their agents any medical information about me needed to determine these benefits or the benefits payable for service.

_____ _____

PATIENT'S OR RESPONSIBLE PARTY'S SIGNATURE DATE

_____

PATIENT'S OR RESPONSIBLE PARTY'S PRINTED NAME

ADVANCE NOTICE BENEFICIARY AGREEMENT

Dear Patient,

Per our contract with your insurance company supplies may not be paid for, should any supplies be issued to you, we will bill your insurance as a courtesy. Any balance portion that is denied by your insurance company will be applied to your patient balance.

BENEFICIARY AGREEMENT

My therapist has notified me that, in case my insurance company may deny payment for the supply/supplies issued. I hereby understand that if I receive any supplies that I will be personally and fully responsible for payment.

_____ _____

Patient's Signature Date

_____

Patient's Printed Name

HIPPA COMPLIANT

AUTHORIZATION FOR THE RELEASE OF

PROTECTED HEALTH INFORMATION

RE: _____

This Authorization authorizes the release of Protected Health Information pursuant to 45 CFR section 160 and 164

1. The undersigned authorizes _____ to release copies of the following information: any and all medical records and billing statements including, but not limited to, notes, memoranda, correspondence, telephone call records, conclusions, diagnosis referrals, recommendations, physical therapy and rehabilitation records and notes, records or health care providers or any other written documentation relating to my treatment and/or care.
2. The information may be disclosed by employees or business associates of _____.
3. The information may be disclosed to:
   _____
   _____
   _____

OR ANY OF ITS REPRESENTATIVE OR DULY AUTHORIZED AGENTS

4. The disclosure may be made for the following purpose: **investigation, negotiation, litigation, conclusion and/or settlement of my bodily injury claim**.
5. This authorization will remain valid until the claim settles, or otherwise concludes, through negotiation and/or litigation however, in no case will this authorization remain valid for more than three (3) years from the date signed.
6. I acknowledge:
   a) That I have the right to revoke the authorization in writing sent by certified mail to _____ and
   b) That I understand that once the information is disclosed, it may no longer be protected by federal privacy law. The revocation shall be effective only upon receipt, except:
      I. To the extent that _____ has acted in reliance on the authorization or
      II. The authorization was obtained as a condition of obtaining insurance coverage and the insurer wishes to use the protected health information to lawfully contest a claim.

_____ _____

Signature Date

_____

Printed Name

Address: _____

Patient's SS# _____ DOB: _____

If person signing is other than patient, state authority under which signature is made:

_____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INORMATION

PLEASE READ IT CAREFULLY

NOTICE OF PRIVACY POLICY

EFFECTIVE:

This Signature Page in reference to the forms entitles:

Notice of Privacy Practices for Protected Health Information

If you did not receive these documents, or have misplaced them, please ask for another copy.
This signature page is in reference to the Federal HIPPA Privacy Regulations requirements.

The undersigned certifies that he/she has received a copy of the Notice of Privacy Practices for Protected Health Information, and is the client, or is duly authorized by the client as the client's representative. If a more detailed verbal explanation is needed, in addition to the one you received, please request one now and we would be pleased to assist you.

_____ _____

Patient Signature (or Patient's Representative) Date