Patient Information

Date:_____/_____/_____

First Name:_____ Last Name:_____

Date of Birth:____/____/____

Home address: _____(Street) _____(City)

_____(State) _____(Zip Code)

Home Phone Number: ( ) _____-_____ Cell Phone Number: ( ) _____-_____

Email address:_____@_____

Best method to be contacted: ___ Home Phone ___ Cell Phone ___ Email

Emergency Contact: _____(Name) ( ) _____-_____(Phone)

▢ Married ▢Single ▢ Widowed ▢ Divorced ▢ Other:_____

▢I Do▢ Do Not have a Do Not Resuscitate Order

▢ I Do ▢ Do Not have a Living Will

Insurance Information

Primary Insurance: ▢Aetna ▢ Blue Cross Blue Shield ▢Cigna ▢Medicare

▢ Tricare ▢ Workers' Compensation ▢ United Health Care

▢ Auto Insurance ▢ Presbyterian ▫ Other_____

If Policy Holder is not patient please fill out the information below:
Policy Holder's Name: _____
Policy Holder's SS#: _____-_____-_____
Policy Holders Date of Birth: _____

Secondary Insurance:_____

Secondary Insurance: Policy/Id Number:_____Group Number:_____

Copay:_____/visit

Deductible:_____

Medicare cap remaining:_____

Law firm/Attorney:_____

Case Manager/Adjuster_____

Do you have an HRA(healthcare reimbursement account) or HSA (healthcare savings account)?

▢Yes ▢ No

If yes, how does it work? ▢HRA/HSA will reimburse the clinic ▢HRA/HSA reimburses me

▢ I don't know HRA/HSA Administrator Name:_____ Policy #_____

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Health History

Basic Information:

▢Male ▢ Female Height:_____ Weight:_____

Treatment Side: ▢ Left ▢ Right ▢ Neck ▢ Lower Back ▢ Middle Back ▢Dizziness/Balance

Date Injury Occurred or Date first date you noticed the symptoms:_____/_____/_____

Surgery Date: _____/_____/_____ Surgical Procedure:_____

Briefly describe your injury (the reason you are being seen today):_____

_____

Pain:

Pain Location: _____

Pain Description: ▢ Dull ▢ Burning ▢Aching ▢ Sharp ▢ Other_____

Pain Scale (0 Being No Pain / 10 Being emergency room):

At worst 0 1 2 3 4 5 6 7 8 9 10

Current 0 1 2 3 4 5 6 7 8 9 10

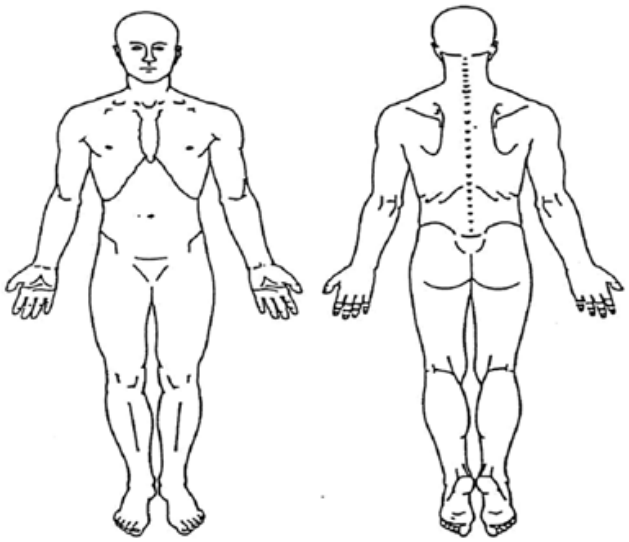
At best 0 1 2 3 4 5 6 7 8 9 10

Pain / Symptoms:

On the Body Diagram, indicate your region of pain using the symbols below.

(X) : Sharp (+): Numb/Tingling (#): Dull/Aching

(B): Burning



What Increases your Pain?

▢ Sitting

▢ Standing

▢ Walking

▢ Stairs up and down

▢ Bending

▢ Lifting

▢ Reaching

▢ Other

Past/Present Medical History:

▢ Osteoarthritis ▢Thyroid ▢Vertigo ▢ Cardiovascular Disease ▢ High Blood Pressure

▢Diabetes Mellitus Type 1/2 ▢High Cholesterol ▢ Tape Allergies ▢Latex Allergies ▢ TMJ

▢ Osteoporosis ▢ Migraines ▢ Cancer (type)_____

▢Other_____

Have you had any of the following?

__ Blood in sputum	__ Loss of consciousness or altered mental status	__ Pathological changes in bowel and bladder
__Progressive neurological deficit	__ Pulsatile abdominal masses	__ Fever
__ History of cancer	__Long-term corticosteroid use	__ Recent history of unexplained weight loss

Does coughing, sneezing or taking a deep breath aggravate your symptoms? Yes__ No__
Does bending, sitting, lifting or twisting your back aggravate your symptoms? Yes__ No__
Has there been any change in bowel habit since onset of your symptoms? Yes__ No__
Does eating certain foods aggravate your symptoms? Yes__ No__
Has there been any weight change since onset of symptoms? Yes__ No__
During the past month have you often been bothered by feeling down, depressed or hopeless? Yes__ No__
During the past month have you often been bothered by little interest or pleasure in doing things? Yes__ No__
Is this something with which you would like help? Yes __ No__
Have you had any unexplained weight loss? ▢Yes ▢ No

Current Medications:

▢ Pain (like hydrocodone) ▢ Birth Control (like Ortho Tri-Cyclen) ▢ Muscle Relaxer (like Flexiril)

▢ Thyroid (like Synthroid) ▢ Sleep Aide (like Lunesta)) ▢ Blood Thinner (like Heprin)

▢ Anti-inflammatory (like Alleve) ▢ Anti-depressant (like Zoloft)

▢ Antibiotic (like Penicillin) ▢ Cholesterol (like Lipitor) ▢ Blood Pressure (like Lisinopril)

▢ Diabetes (like Metformin) ▢ Other_____

Occupation:_____

Work Status: ▢ Full time ▢ Part time ▢ Not working ▢ Light Duty ▢ Retired

▢Disabled

Other:_____

Imaging Studies (for the condition you are here for): ▢ X-rays ▢ MRI ▢ CT SCAN ▢Bone

▢ Other:_____

PT FIRST Payment Policies

Payment Policy:

1. Payment for services per your insurance plan in the form of a *copay or deductible* will be collected at the time of service.
2. Your deductible payment will be determined based on your insurance fee schedule and your percent responsibility.
3. Payment can be made in the form of cash, check, credit card and an applicable health savings plan or health reimbursement account.
4. As a courtesy, PT FIRST will verify your insurance benefits for physical therapy. We encourage you to call and verify your benefits as well.
5. You must provide accurate insurance information and comply with requests from your insurance company to ensure prompt payment.
6. If your account balance is more than 60 days past due, you will be charged 1.5% per month. You will receive a max of 2 statements.
7. There will be a $30.00 processing charge for each returned check.
8. If your account is sent to a collections agency, then you are responsible for payment of the costs associated with collections.
9. You will be charged $30.00 for appointments canceled with less than 24 hours notice.

Initial_____

Acknowledgement of receipt of Privacy Practice Notices

I _____, hereby acknowledge that I have reviewed a copy of this office's Notice of Privacy Practices explaining:

- How this office will use and disclose protected health information.
- My Privacy Rights with regard to protected health information
- This offices obligation regarding the use and disclosure of protected health information

Signature:_____ Date:__/___/____

Printed Name:_____

Relationship to Patient:_____

PT FIRST Consent Form

Consent:

•I, the patient, or as agency, spouse, parent or guardian of the patient, hereby authorize and consent to: the administration of treatment, procedures and modalities that are deemed necessary and/or desirable by the staff and /or employees of PT FIRST.

•I, the patient or as agency, spouse, parent or guardian of the patient do: authorize PT FIRST to release any medical or other information necessary to my insurance company, my attorney and/or my prescribing physician, to process this claim.

•I, the patient or as agency, spouse, parent or guardian of the patient, do: authorize payment of medical benefits to be sent directly to PT FIRST for services rendered.

•I, the patient or as agency, spouse, parent or guardian of the patient, do: understand and agree that regardless of my insurance status, I am responsible for the balance on my account for any professional services rendered by PT FIRST.

•I have read all the information contained herein and have initialed my understanding above. I certify that the information is true and correct to the best of my knowledge. I will notify PT FIRST Physical Therapy of any and all changes in my health status or the information I have provided herein.

•I consent to and authorize all therapy treatment, which in conjunction with the judgment of the attending physician may be considered necessary or advisable for the diagnosis or treatment of the above named patient at PT FIRST. I understand that I may experience some pain or discomfort during and after treatment.

_____Signature

PT FIRST Consent to Treatment of a Minor

I authorize PT FIRST, its licensed therapists, and its staff that may be designated to administer therapeutic care as deemed necessary to my_____,

(child's name)_____.

Parent/Guardian Name_____.

Parent/Guardian Signature_____.

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PT FIRST Physical Therapy Plan of Care:

Your doctor and therapist agree that skilled physical therapy is necessary. Your plan of care as agreed to is _____ visits per week for _____ weeks.

In the event you need continued skilled therapy it may need to be authorized by your insurance and/or referring physician.

To better serve your therapy needs, when are you available to attend physical therapy?

I am available the following appointment days.

▢ M ▢ T ▢ W ▢ R ▢ F ▢ S

I am available the following times:

▢ Early ▢ Mid-Morning ▢ Early Afternoon ▢ Late Afternoon

Other:_____.

Patient Signature:_____.

Therapists Signature:_____

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