Patient Information

Name: _____
Date of Birth: _____
Address: _____
City:_____State:_____Zip:_____
Email:_____
Home Phone#:_____
Mobile Phone#:_____
Occupation: _____
Employer: _____
Work Phone#:_____
Insurance Company: _____
Insured Name: _____
Relationship: _____
Insured D.O.B._____
Card#:_____
Referring Physician: _____
Phone#:_____
Primary Care Physician: _____
Phone#:_____

Emergency Contact

Name:_____
Relationship_____
Home Phone#:_____
Work Phone#:_____
Mobile Phone#:_____

How did you hear about us? (Circle one)
MD Returning Patient
Friend/Family Insurance Internet Search
APTA Mailer Other_____

HIPAA Compliance

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

X_____Date: _____

Agreement and Release

As a courtesy to you, we will call and verify your insurance coverage. However, we will not be responsible for incorrect information given to us by yourself or your insurance representative. Therefore, it is your responsibility to be aware of your own plan and its conditions.

You are responsible for any deductibles, copays, or any other non-covered services per your individual policy. If your policy or plan changes during the time of treatment, you must notify us immediately. Failure to do so may result in a balance owed by you.
For **Auto/Workers Compensation** benefits, your insurance carrier does not tell us the remaining benefits. This is your responsibility to find out this information.

Cancellation Policy

- If you cancel an appointment, 24 hour notice will be needed, otherwise a $30.00 charge will be assessed. Insurance companies require that we document the reason for all cancellations.

- $30 NO SHOW CHARGE – A "no show" is defined as a patient who does not cancel their appointment, but simply does not come. Since the time block has been reserved, this prevents us from scheduling someone else in a lost income.

I understand all the aforementioned.

X_____Date:_____

Medicare Authorization

I understand that my signature requests that payment be made and authorize the release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of HCFA 1500 form or elsewhere on other approval claim forms of electronically submitted claims, my signature authorizes release of information to the insurance agency shown. Co-insurance and deductible are based upon the charge determination of the Medicare carrier.

X_____Date:_____

Under 18 Years Old – Release

To allow your child receive therapy treatment without his or her parent/guardian present, please sign below

X_____Date: _____

MEDICAL INTAKE

PATIENT NAME:_____**AGE:**_____

Primary reason for visit:_____

Injury/Onset Date:_____□ Chronic □Insidious_____

Surgery Performed:_____ If so, date:_____Type of Surgery:_____

Prior to your injury were you independent with:	**Current Limitations**
□Daily Activities □Self Care □Work/Vocation □Caregiving □Community Intergration/Access □Ambulation/Mobility □Other_____	□Sleep □Self Care □DailyActivities □Sitting/Stand □Reaching/Pushing/Pulling □Lifting/Carrying □Bending/Squatting □Ambulation/Mobility □Other_____ □CommunityIntergration/Access

Occupation/Work Status: □Part Time □Full Time □Light Duty

Are you currently working: □Yes □No

Main Complaints/Restrictions: _____

Pain Scale	**0 = None**		**5= Moderate**		**10=Extreme**						
	0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
At Worst	□	□	□	□	□	□	□	□	□	□	□
Current	□	□	□	□	□	□	□	□	□	□	□
At Best	□	□	□	□	□	□	□	□	□	□	□

Pain Description:

□Not Tested □ Burning □Dull/Achy

□Throbbing □ Shooting □Numbness/Tingling

□Other_____

Pain Location_____

Current Medications & Dosages:

□Prescriptions/Over the Counter/Herbs/Vitamins

_____

_____

_____

Previous Medical History:

□No Medications

□Osteoarthritis □Cardiovas Disease □Diabetes Type 1 □Diabetes Type 2

Surgical History_____ Other_____

Diagnostic Testing: □ X-Ray □ MRI □ CT Scan □Other_____

What are your goals for physical therapy_____

Previous Physical Therapy When_____Where_____