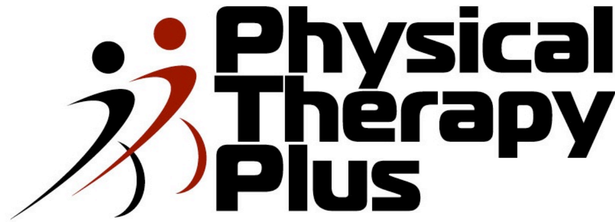


NEW PATIENT INFORMATION

*****No P.O. Box Addresses*****

Client Information:

Legal Name: ____DOB: __________ Age: _________

Nickname:______________________________ **SSN:** __________________________ ☐ Male ☐ Female

Address:__________________________________ City: __________________ State: ______ Zip: ______

Home phone: ______________________ Cell: _________________ Work: _______________________

Employer: _______________________________ Retired Y N Student Y N Married Y N

Email Address:____

Your Referring MD:_____________________________ Your Family MD_____________________________

Date of your injury or surgery:______________ Was your injury due to: ☐ Auto Accident ☐ Work Injury ☐ Other

Have you had Physical Therapy Before? Y N If yes, when? ______________ How long?_______________

Are you currently receiving any home health services? Yes No

Responsible Party Information (Please fill out if client is minor)

Name: _______________________________ DOB______________ SSN__________________________

Address: _______________________________City ___________________State: ________ Zip: ________

Home phone: ______________________ Cell: ______________________ Work: ____________________

Emergency Contact:

Name:_________________________________Relationship:____________Phone:____________________

POLICY HOLDER INFORMATION:

Insurance Company: _________________________ Insurance ID # _______________________________

Policy Holder Name: ______________________________Policy Holder Date of Birth: ____________________

Policy Holder's Employer _____________________________ Policy Holders SSN _____________________

Policy Holder address if different than client: ____

Client relationship to insured (please circle one): ☐ Self ☐ Spouse ☐ Child ☐ Other

Secondary Insurance:

Insurance Company: _________________________ Insurance ID # _______________________________

Policy Holder Name: __________________________Policy Holder Date of Birth _______________________

Policy Holder's Employer _____________________________ Policy Holders SSN _____________________

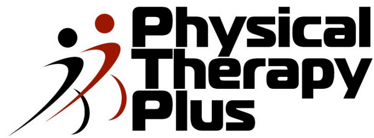
Policy Holder address if different than client: ____

Client relationship to insured (please circle one): ☐ Self ☐ Spouse ☐ Child ☐ Other

How did you hear about us? (check one) ☐ Physician ☐ Telephone book ☐ PT Plus Newsletter

☐ Friend/Relative ☐ Newspaper ☐ Website ☐ Other:____________________

PLEASE RETURN THIS FORM WITH INSURANCE CARD AND PICTURE ID



Medical History

Condition	Y	N	Condition	Y	N
Allergies	Y	N	Gallbladder Problems	Y	N
Anemia	Y	N	Hepatitis	Y	N
Anxiety	Y	N	High Blood Pressure	Y	N
Arthritis	Y	N	Incontinence	Y	N
Asthma	Y	N	Kidney Problems	Y	N
Cancer	Y	N	Metal Implants	Y	N
Cardiac Conditions	Y	N	Multiple Sclerosis	Y	N
Cardiac Pacemaker	Y	N	Osteoporosis	Y	N
Chemical Dependency	Y	N	Parkinson's	Y	N
Circulation Problems	Y	N	Rheumatoid Arthritis	Y	N
Currently Pregnant	Y	N	Seizures	Y	N
Depression	Y	N	Speech Problems	Y	N
Diabetes	Y	N	Strokes	Y	N
Dizzy Spells	Y	N	Thyroid Disease	Y	N
Emphysema/Bronchitis	Y	N	Tuberculosis	Y	N
Fractures	Y	N	Vision Problems	Y	N

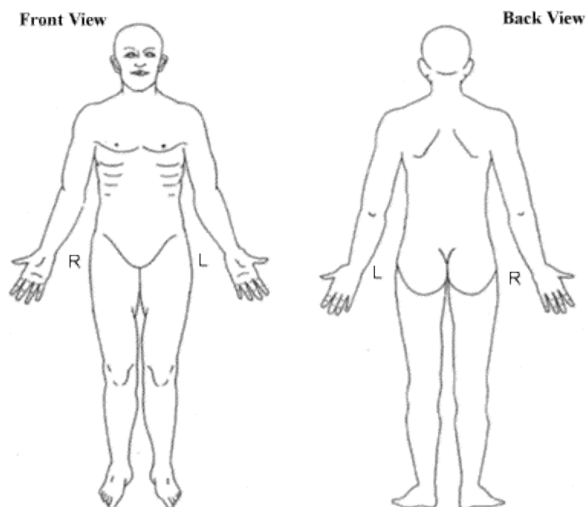
Describe any other conditions or precautions

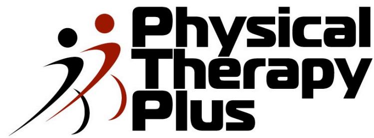
____

____

____

Indicate where you have pain or other symptoms





Fall History

Injury as a result of a fall in the past year? Yes No

Two or more falls in the past year? Yes No

Surgical History

Body region: ______________________ Surgery Type: __________________________

Month of surgery:____________________Type:_________________________________

Body region: ______________________ Surgery Type: __________________________

Month of surgery:____________________Type:_________________________________

Body region: ______________________ Surgery Type: __________________________

Month of surgery:____________________Type:_________________________________

Current Medication:

Drug: ____________________ Dosage_______________Frequency:_____________________

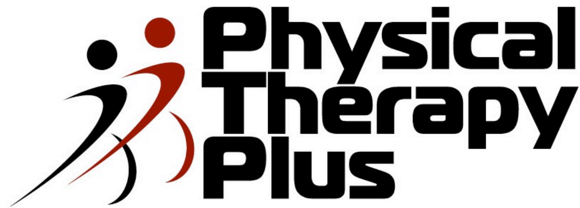
Reason: ____

Drug: ____________________ Dosage_______________Frequency:_____________________

Reason: ____

Drug: ____________________ Dosage_______________Frequency:_____________________

Reason: ____



Release and Consent for Physical Therapy

I have presented myself to this facility for Physical Therapy treatment and consent to care provided by the attending Physical Therapists. I realize that I have the right to refuse treatment. I acknowledge that no guarantees or warranties can be made to me regarding the outcome of any treatment at this facility. I understand that any information from my medical records may be used for educational or administrative purposes; however, my identity will not be revealed. I also realize that if I am a Worker's Comp patient that my records will be shared with my case manager.

I, authorize Physical Therapy Plus to release and/or obtain the following information related to my treatment:
Insurance and Referring MD must be checked in order to file your claim.

________ Insurance Company Name: ______________________________ Phone: ________________

________ Employer Name: ______________________________ Phone: ________________

________ Spouse Name: ______________________________ Phone: ________________

________Parents/Guardian Name: ______________________________ Phone: ________________

________Referring Physician: Name: ______________________________ Phone: ________________

____ ______________________________
Signature of Patient/ Parent/ Guardian Date

Acknowledgement of Receipt of Notice of Privacy Practices

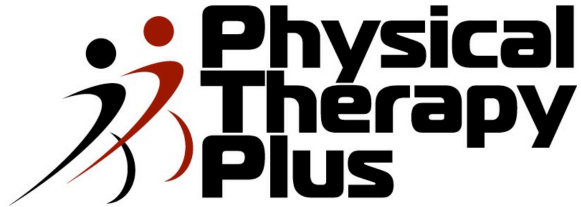
Your information will be kept private and secure. Any information requested by an outside source, such as an Insurance company or doctor's office, will require proper authorization from the patient.

____Yes, I have been made aware of Physical Therapy Plus' Privacy Policy and have been offered a copy of the HIPAA Statement

X______________________________________ _________ X________________________________ __________
Employee Signature Date Patient/Parent/Guardian Signature Date

Would you like a complimentary reminder of your appointment?

Phone:________________________________
Email:_________________________________
Cell Phone:_________________________________
(PT Plus will not be liable for any charges that may apply)



Physical Therapy Plus
Fees and Collections Policy

I understand that I am fully responsible for payment of services rendered to me, by the above practice, before the session begins**.** I realize that my Physical Therapy benefits have been determined prior to this appointment and it is company policy to collect all co-payments, co-insurance, and deductible payments before each visit**.** I understand that I am financially responsible for charges not covered by my insurance and agree to guarantee payment for any balance due. **Any unpaid balance after 90 days will be subject to 7% interest.**

No-Show/Late Cancellation Fees

A fee of **$25.00** will be added to the account of any patient failing to cancel an appointment 12 hours prior to appointment time. A patient is considered a "no-show" if the appointment is not kept and not canceled 12 hours prior to the scheduled time. These charges are not covered by health insurance benefits and are the responsibility of the patient/responsible party. Patients with no-show fees must clear the charge prior to the next scheduled appointment.

Miscellaneous

Requests for medical records: The patient will receive 1 free copy of their medical records. Additional requests are $1.00 per page plus postage and handling fees.

Collection Procedures

Our office reserves the right to place all accounts 30 days past due into collection procedures.

Returned Checks

There is a $35 fee for checks returned for insufficient funds. The patient will then be required to use cash, money order, or credit card for all future transactions. A letter will be mailed, giving the patient 10 days to redeem the check in cash or money order. After 10 days, the check will be handed over to the County Attorney's Office for collection.

I have read, understand and agree to the above policy.

____

Patient or Parent/Guardian Signature Date