First Name: ____

Last Name: ____MI: _____________

Preferred Name: ____

Sex: MALE / FEMALE / DECLINE TO ANSWER

Home Phone: _______________ Work Phone: _______________ Cell Phone: _____________

Home Address: ____

City: _____________________________State:_________________ Zip: ______________

Date of Birth: ______/______/______ Social Security Number: ________ - _______ - _______

How did you hear about Physical Therapy Professionals? _________________________________

Emergency Contact: ___________________ Relationship: ____________ Phone #: ___________

For billing purposes if you have an alternate address please list below. Please include the date range that you normally reside at this secondary address:

Address: ____

City: _________________________ State: _____ Zip: __________ Dates: ______________

Please provide your email address below to avoid charges for mailing requested medical records and / or outstanding financial statements. To ensure your privacy all email will be sent over a secure network and your address will not be shared publicly to any third party. If you have questions in regards to the above, please see the receptionist.

Email address: ____

I understand and agree that I am responsible for the balance of my account for any services rendered. I have read all the above information and the information provided is true and correct to the best of my knowledge. I will notify Physical Therapy Professionals of any changes with the above information. I hereby authorize any treatment(s) agreed upon with my physical therapist and my referring provider (if applicable) that are deemed medically necessary.

Patient Signature: _____________________________________ Date: ______/______/______

Patient Name: ____ DOB: __________________________

Consent for Treatment

I, the undersigned do hereby agree and give my consent for Physical Therapy Professionals, LLC to furnish medical care and treatment which is considered necessary and proper in the diagnosing or treating of my physical conditions.

Signature ____ Date __________________________

Benefit Assignment/ Release of Information

I, the undersigned, hereby assign all medical benefits, i.e.: Medicare, Private insurance, major medical benefits, Worker's Compensation and any other health plans to which I am entitled to Physical Therapy Professionals. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize Physical Therapy Professionals to release all medical information and records necessary to secure payment for services.

Signature ____ Date ______________________

Financial Policy Statement/ Insurance Verification

Primary Insurance Carrier: Policy#

Deductible: $ $ has been met

Copay/ Coinsurance: $

Secondary Insurance Carrier:

Comments: You will be responsible for a ($) copay for the initial visit and a ($) per visit until deductible has been met. After that, you will be responsible for a (%) coinsurance until the out-of-pocket maximum has been met. After that, your insurance quotes that you will be covered at 100%.

By initialing here, you are acknowledging that the amount being collected IS AN ESTIMATE and you may owe more/less depending on how your insurance processes our claims. PATIENT WILL BE RESPONSIBLE FOR ANY CHARGES NOT COVERED BY THEIR INSURANCE. If an over-payment has occurred, you will receive a refund check once all claims have been processed. Initials: _______________

PT Professionals will bill your insurance company as a courtesy to you. In most cases, we have an agreement with your insurance company to handle payments for your physical therapy. If your insurance company does not remit payment within 60 days from the date submitted (a universally accepted time period), PT Professionals reserves the right to collect the full balance from you. The above information may not apply to those receiving Worker's Compensation benefits. However, be advised if you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you .I understand and confirm that if I fail to make any of the payments for which I am responsible in a timely fashion, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and/or attorney fees. I give consent to PT Professionals to treat me for this condition, and I understand my responsibility for the payment of my account. I have read the above information and/or it has been explained to me and I accept the terms and conditions of the above and will be responsible for payment of my account.

Signature ____ Date ________________________

Cancellation Policy

We have multiple methods available to remind you of your appointments and it is your responsibility to attend scheduled appointments. Late notice cancellations or no shows harm our practice and will likely affect your recovery. If you fail to attend a scheduled appointment or cancel with less than 24-hour notice, any future no show or late notice cancellations will result in all future appointments being deleted. A $50 no-show fee will be charged before additional appointments can be scheduled and will be also be charged for any future missed visits without proper notification. Initials: ____________

Home Health

Most insurance companies will not cover out-patient physical therapy if you are receiving Home Health Care of any kind at the same time. **By initialing below, you indicate that you are currently not receiving any type of home care** including nursing, occupational therapy or physical therapy from a Home Health Agency. It is also your responsibility to inform us if you initiate home health care for any reason during the course of your treatment with us or you will be responsible for any denied payments that result from concurrent treatments. Initials: ____________

Acknowledgement of Receipt of Notice of Privacy Practices

This facility will make every attempt to protect your privacy and personal information. We have provided a summary of your rights and protections under the federal health information privacy law. We would like to retain your signature to acknowledge the receipt of our notice of privacy practices.
You will receive a copy of the Privacy Practice Notice on your first appointment

I have received a copy of the notice of privacy practices at PT Professionals.
Initials: ____________

Option to Give Access to Medical Records

I authorize_______________________________(Examples: Spouse, Sibling, Parent, Caregiver) access to medical information pertaining to my treatment. Please note that PT Professionals will not share your information with any individual that are not involved with your case unless you specify otherwise.

Please note that if you are 18 years or older, we cannot release your information to any other individual that does not have a business associate agreement with PT Professionals and is not directly involved with your case unless you otherwise specify.

Appointment Reminder Notifications

Would you like to receive free appointment reminder notifications via text message, phone call or e-mail message?

☐ Text Message (Phone Number): ______________________________

☐ Phone Call (Phone Number): ______________________________

☐ Email (Email Address): _________________________________

☐ No Reminders

Email Newsletter

Would you like to be included on our email list to receive our newsletter and updated clinical information and health tips from PT Professionals?

☐ Email: _________________________________

☐ Not Interested

DISCLAIMER
We will not use this information for any other purpose than to contact you via the PT Professionals mailing list & PT Professionals contact list. We WILL NOT pass your email address, phone number or other information to other companies. You may at any point have your details removed from our database by contacting our webmaster.

PHYSICAL THERAPY Professionals

Patient Name: ________________________________ Referring practitioner: _____________________

Is this a Work-related Injury? ☐ Yes ☐No   Is this related to an Auto Accident? ☐ Yes ☐ No

Is there an attorney involved in this case? ☐ Yes ☐ No

Have you had surgery for this condition? ☐Yes ☐ No If yes, date: ___________________________

Have you received previous treatment for this condition? ☐Yes ☐ No If yes please describe:

____

Are you a previous patient of PT Professionals? ☐ Yes ☐ No

Are you currently receiving or have you received in the last 30 days any home health, medical or chiropractic services rendered to you by any other agency? ☐Yes ☐ No If yes, please describe:

____

Are you currently taking any medications **for this injury**? ☐YES   ☐NO

☐Anti Inflammatories ☐Muscle Relaxers ☐ Pain Medication ☐ Other: _______________________

At the present time, would you consider your overall health:

☐ EXCELLENT ☐ VERY GOOD ☐ FAIR ☐ POOR

Females: Are you currently pregnant? ☐YES ☐ NO

Do you now have, or have you ever had any of the following?

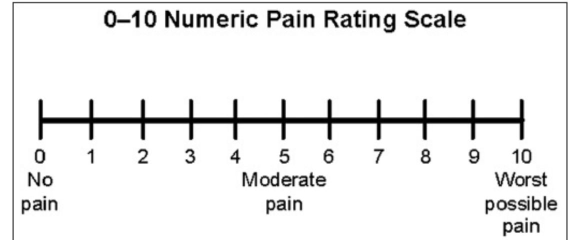
Condition		
Pacemaker and/or defibrillator	☐ YES	☐ NO
Diabetes	☐ YES	☐ NO
Coronary Artery Disease/Angina	☐YES	☐ NO
Shortness of Breath/Chest Pain	☐YES	☐ NO
Heart Attack/Heart Surgery	☐ YES	☐ NO
Latex Sensitivity/Allergy	☐ YES	☐ NO
Blood Clot	☐ YES	☐ NO
High Blood Pressure	☐ YES	☐ NO
Osteoporosis	☐ YES	☐ NO
Pin/Metal Implants	☐ YES	☐ NO
Asthma, Bronchitis or Emphysema	☐ YES	☐ NO
Headaches	☐ YES	☐ NO
Dizzy Spells/Fainting	☐ YES	☐ NO
Stroke/TIA	☐ YES	☐ NO
Thyroid Trouble/Goiter	☐ YES	☐ NO
Joint Replacement	☐ YES	☐ NO
Infectious Disease (explain below)	☐ YES	☐ NO
Arthritis	☐ YES	☐ NO
Sleeping Problems	☐ YES	☐ NO
Do you Smoke?	☐ YES	☐ NO
Numbness/Tingling	☐ YES	☐ NO
Weakness	☐ YES	☐ NO
Unexplained Weight Loss/Gain	☐ YES	☐ NO
Hernia	☐ YES	☐ NO
Epilepsy/Seizures	☐ YES	☐ NO
Recent changes in Bowel/Bladder	☐ YES	☐ NO

Allergies: ______________________________________

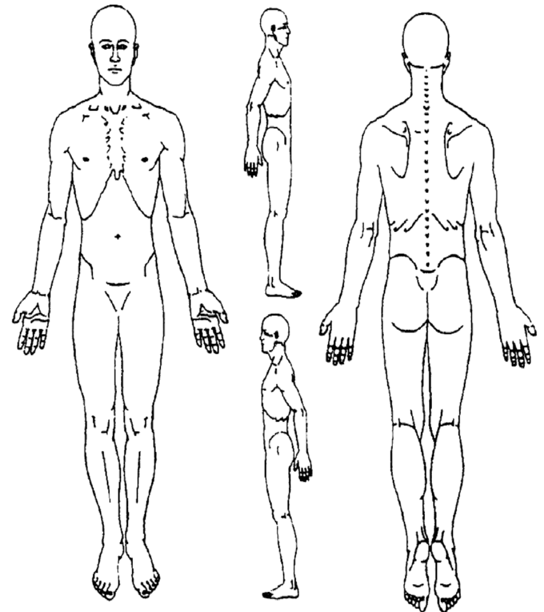
Cancer (Please Explain):__________________________

____

On a scale of 0-10,
(0 being no pain and 10 being at its worst)
Please rate your pain at best ____ at worst ____



Please mark the areas on the diagram below where you feel the pain.



Please list any other health conditions:

____

____

____

Patient Signature:____ Date: ______________________

PHYSICAL THERAPY Professionals

Patient Name: ______________________________ D.O.B: ____________________

Medication List

*** This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications name, dosage, frequency and route of administration***

Medication	Dosage	Frequency	Administration Method

☐ I am not taking any Medications at this time.

Patient Signature:_____________________________________ Date: ____________________