ExcePTional Physical Therapy

DATE:_____

PATIENT INFORMATION

NAME:_____
First Middle Last

ADDRESS:_____
Street/ Mailing City State ZIP

GENDER: Male Female SOCIAL SECURITY NUMBER:_____-_____-_____ DOB:_____/_____/_____

PHONE: Home_____ Cell_____ Work_____

EMAIL:_____ APPOINTMENT REMINDERS: Text Email No

EMERGENCY CONTACT:_____ Relation:_____ Phone:_____

EMPLOYER:_____
Name Address

RESPONSIBLE PARTY *Responsibility party MUST fil out the section below if the patient is a MINOR*

NAME:_____ _____
FIRST MIDDLE LAST RELATION

ADDRESS:_____
Street/Mailing CITY STATE ZIP

PHONE #:_____ DOB:_____/_____/_____ SOCIAL SECURITY NUMBER:_____

EMPLOYER:_____
NAME ADDRESS

INSURANCE INORMATION

PRIMARY INSURANCE: _____ INSURED NAME: _____
PHONE #: _____ POLICY ID#: _____

SECONDARY INSURANCE:_____ INSURED NAME:_____
PHONE #:_____ POLICY ID:_____

ACCIDENT INFORMATION

IF THIS INJURY IS FROM AN ACCIDENT, WHAT DATE DID THE ACCIDENT/INJURY OCCUR: _____
TYPE OF ACCIDENT: MOTOR VEHICLE ACCIDENT WORK RELATED OTHER:_____

HISTORY & PHYSICAL

PATIENT NAME_____ **DOB**_____/_____/_____

OCCUPATION:_____ HOBBIES: _____

CHIEF COMPLAINT/ PROBLEM: _____

DATE OF ONSET:_____ GRADUAL ONSET or SUDDEN ONSET

Status: Single Married Widowed

WORK STATUS:

__work without restrictions __work the same job with restrictions __work different job with restrictions
__unable to work due to dysfunction __homemaker __retired

HAVE YOU SOUGHT PREVIOUS TREATMENT FOR THIS CONDITION?

__no other treatment __massage therapy __chiropractor __physical/ occupational therapy
__psychiatrist/ psychologist __other: _____

WHAT TESTS OR PROCEDURES HAVE BEEN DONE FOR YOUR CURRENT CONDITION:

__X-RAYS __MRI/ CT SCAN __EMG __EKG __BLOOD WORK __OTHER: _____

We can make a copy of your medications and surgeries if you have a list

MEDICATIONS	DOSAGE	FREQUENCY	REASON
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SURGERIES OR OTHER CONDITIONS FOR WHICH YOU HAVE BEEN HOSPITALIZED:

DATE	SURGERY/ HOSPITALIZATION REASON	BODY REGION
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has anyone in your immediate family ever been treated for any of the following?

__cancer __heart disease __diabetes __tuberculosis __stroke __mental disorder __arthritis
__high blood pressure __other

HAVE YOU HAD ANY FALLS IN THE PAST YEAR? YES NO If yes, how many? _____

ARE YOU CURENTLY HAVING OR HAVE EXPERIENCED ANY OF THESE SYMPTOMS?

__Allergies: If yes, what kind?_____

__ANEMIA	__PACEMAKER	__DIZZY SPELLS
__ANXIETY	__CHEMICAL DEPENDECY	__EMPHYZEMA/ BRONCHITIS
__ARTHRITIS	__CIRCULATION PROBLEMS	__FRACTURES
__ASTHMA	__DEPRESSION	__GALLBLADDER PORBLEMS
__CANCER	__DIABETES	__HEPATITIS
__CARDIAC CONDITIONS	__HIGH/ LOW PRESSURE	__INCONTINECE
__KIDNEY PROBLEMS	__METAL IMPLANTS	__MULTIPLE SCLEROSIS
__OSTEOPOROSIS	__PARKINSONS	__RHEUMATOID ARTHRITIS
__SEIZURES	__SPEECH PROBLEMS	__STROKE
__THYROID DISEASE	__TUBERCULOSIS	__VISION PROBLEMS
__AUTOIMMUNE DISORDER	__CURRENTLY PREGNANT	__FIBROMYALGIA
__HEARING IMPAIRMENT	__HIGH CHOLESTORAL	__HIV/ AIDS
__MRSA	__MUSCULAR DISEASE	__SMOKING

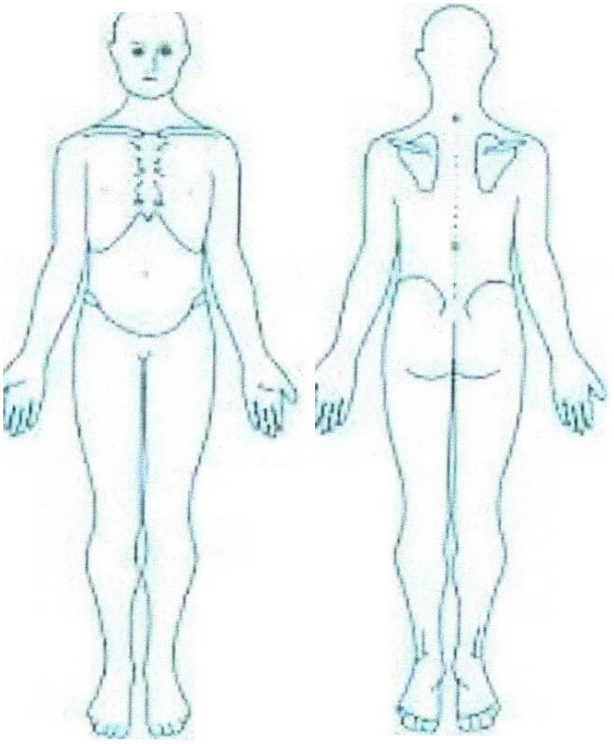
__OTHER:_____

PLEASE MAP YOU AREAS OF DISCOMFORT ON THE SCALE BELOW:

xxx = pain

000 = numb/tingle

*** = weakness



RATE YOUR AVERAGE DISCOMFORT ON THE SCALE BELOW:

0_____10

(no pain) (severe pain)

WHAT IS YOUR GOAL FROM PHYSICAL THERAPY?

_____

_____

_____

OTHER COMMENTS OR CONCERNS YOU MAY HAVE:

_____

_____

HOW DID YOU HEAR ABOUT US?_____

REFERRING PHYSICIAN_____ **PCP**_____

STATEMENT OF FINANCIAL RESPONSIBILITY

Please read the following carefully. The payment policy is as follows. All charges are expected to be paid in full unless prior arrangements have been made.

- Initial Office Visits: Your initial office visit charges will be filed at your request, but you will be expected to pay any remaining coinsurance and deductible amount that is not met.
- Uninsured patients: You are required to pay an initial ($185) and follow up visit ($85 each) payment at the time of each visit. Payments can come in the form of cash, check, or credit card. Please contact our office, either in person or by phone, for details of payment arrangements.
- Co-pays: You will be expected to pay your insurance co-pay at each appointment. This cannot be billed.
- Follow-up visits: We will file your insurance for you on follow-up visits, but you will also be expected to pay your coinsurance/copay and any deductible not met.
- Non-covered charges: you will be responsible for all non-covered charges not payable by your insurance company.
- **I understand that there is a $50 fee for each No-Show appointment.**
- **I understand that there is a $50 fee if an appointment is not cancelled the day before by 2:00 pm.**
- **I understand that arriving late may result in a cancellation.**

I have been informed of my financial responsibility and agree to the terms and conditions as stated on this form.

X_____

Signature Date

X_____

Office/ Witness Signature Date

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for Exceptional Physical Therapy, PLLC to furnish medical care and treatment to me as considered necessary and proper in diagnosing or treating my physical condition.

X_____

Signature Date

PRIVACY PRACTICE ACKNOWLEDGEMENT

I acknowledge that the Notice of Privacy Practices is posted at the location in which I am receiving treatment and that I have read and understand the notice. I further acknowledge that I have the right to request a copy of the notice.

X_____

Signature Date

PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS IN ACCORDANCE TO HIPAA.

I, _____,understand that as a part of my health care, Exceptional Physical Therapy, PLLC, originates and maintains paper and/or electronic records describing my health history, symptoms, examinations, test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer(s) can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent/disclosure.

I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat met permitted by Section164.520 of the Code of Federal Regulations.

I understand that as part of this organization's treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to another entity (insurance company, referring physician, consulting physician, hospital, etc.), and I consent to such disclosure for these permitted uses, including disclosures via fax or e-mail.

In addition, I also give Exceptional Physical Therapy, PLLC permission to disclose my protected healthcare information to the following person and/or people:

_____

Name Relationship

_____

Name Relationship

_____

Name Relationship

I fully understand and accept the terms of this consent.

X_____

Signature Date