Physical Therapy Specialists

PATIENT INFORMATION

NAME: _____ **D.O.B:** _____ /_____/_____
LAST FIRST MIDDLE

ADDRESS: _____
STREET CITY STATE ZIP

HOME NUMBER: _____ **CELL NUMBER:** _____ **EMAIL:** _____

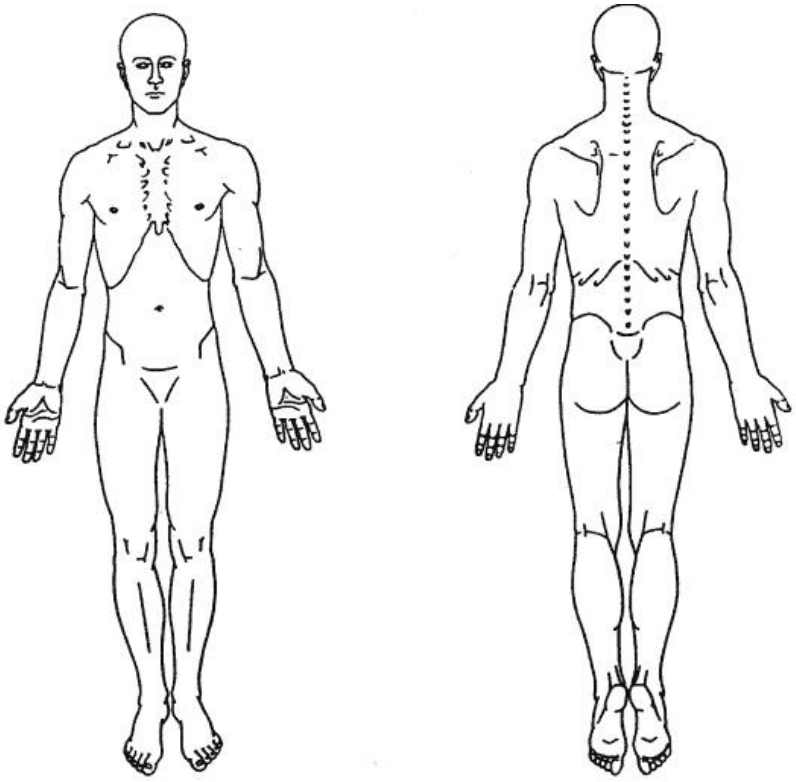
WOULD YOU LIKE AN APPOINTMENT REMINDER? ☐ **NO** ☐ **YES, VIA** ☐ **EMAIL** ☐ **PHONE CALL** ☐ **TEXT**

EMERGENCY CONTACT NAME: _____ **PHONE:** _____ **RELATIONSHIP:** _____

HAVE YOU RECEIVED ANY PHYSICAL THERAPY THIS CALENDAR YEAR? ☐ **NO** ☐ **YES** IF YES, WHEN? _____

ARE YOU CURRENTLY RECEIVING PHYSICAL THERAPY IN THE HOME? ☐ **NO** ☐ **YES**

CIRCLE THE AREA OF PAIN AND INDICATE THE LEVEL OF PAIN BY USING THE 0 TO 10 SCALE 0 BEING "NO PAIN" AND 10 BEING "THE WORST" DESCRIBE:



DO YOU HAVE/OR HAVE HAD ANY OF THE FOLLOWING:
PLEASE CHECK ✓ ALL THAT APPLY.

- ☐ DIABETES
- ☐ METAL IMPLANTS
- ☐ CANCER
- ☐ HIGH BLOOD PRESSURE
- ☐ PREGNANT (PRESENTLY)
- ☐ KIDNEY PROBLEMS
- ☐ HEART DISEASE/ATTACK
- ☐ HEADACHES
- ☐ HERNIA
- ☐ PACEMAKER
- ☐ HISTORY OF SMOKING
- ☐ PREVIOUS SURGERIES
- ☐ STROKE
- ☐ SEIZURES

IF YES TO ANY OF THE ABOVE, PLEASE EXPLAIN AS NECESSARY AND LIST ANY OTHER PERTINENT MEDICAL HISTORY:

_____

_____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING AND THE DOSAGE:

1._____ 2. _____ 3. _____

4._____ 5. _____ 6. _____

ATTENDANCE POLICY AND AGREEMENT

Our goal is to give personal and quality care. A scheduled appointment must be canceled at least **24 hours** in advance. There will be a **$30.00 fee** for failing to cancel under this time frame. The patient is responsible for this fee, not your insurance or 3rd party payor. _____**INITIALS**

CONSENT FOR TREATMENT

I hereby consent to treatment procedures and patient care which, in the judgment of my therapist and/ or physician may be considered necessary or advisable while a patient at Physical Therapy Specialists _____ **INITIALS**

INSURANCE INFORMATION

We require this information to properly bill your insurance.

SUBSCRIBER'S NAME: _____

SUBSCRIBER'S DATE OF BIRTH: _____/_____/_____**RELATIONSHIP TO PATIENT:** _____

FINANCIAL RESPONSIBILITY

We appreciate the opportunity to participate in your medical care. Your health is our concern. Our financial policy is designed to allow us to offer the best medical care to all our patients. It is the patient's responsibility to know your insurance benefits and policy requirements for office visits and procedures (therapy).

As a gesture of courtesy, we offer to initiate billing procedures with your insurance provider at no additional cost. It remains your responsibility to promptly inform us of any modifications to this information. We expect all co-payments, co-insurance, deductibles, or estimated "cash pay" amounts to be settled at the time of service. If your insurance provider declines a portion of your claim, the entire outstanding balance will become your responsibility. I understand it is my responsibility, and agree, to pay all co-payments, co-insurance, deductibles, or "cash pay" estimated amounts at the time of service. _____**INITIALS**

If your insurance does not fully cover our services, you will receive a bill from our office. If you have any billing questions, please contact ERICKA ANDRADE**,** at 8183630339.

ASSIGNMENT AND RELEASE

I authorize payment of benefits to be made directly to Physical Therapy Specialists. I also authorize the release of any information requested to process this claim. _____**INITIALS**

Furthermore, Physical Therapy Specialists may use and disclose protected health information about me to carry out treatment, payment, and healthcare operations. I understand that I have the right to request a copy of the Notice of Privacy Practices. Physical Therapy Specialists reserves the right to revise their Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.
_____**INITIALS**

_____/_____/20_____ _____

DATE **PATIENT, PARENT OR GUARDIAN SIGNATURE**