

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****

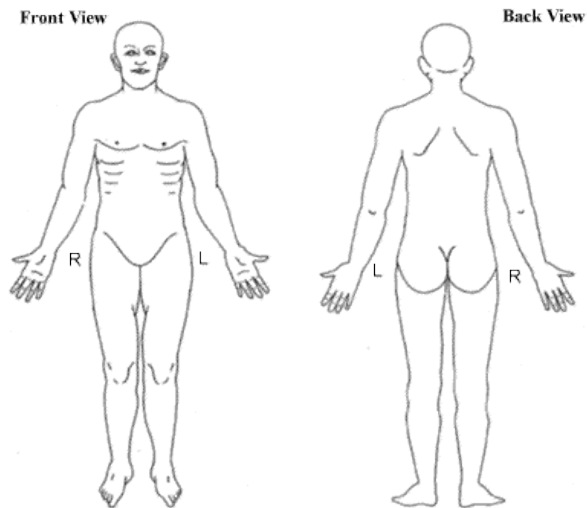


Medical History

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: _____

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Month of surgery: _____ Type: _____

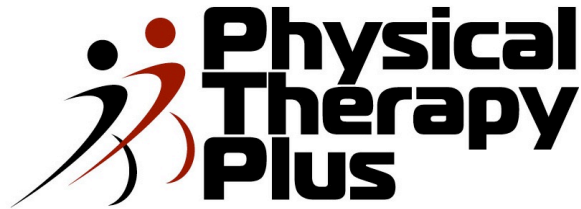
Body region: _____ Surgery Type: _____
Month of surgery: _____ Type: _____

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 _____
Employee Signature

Date

X _____
Patient/Parent/Guardian Signature Date

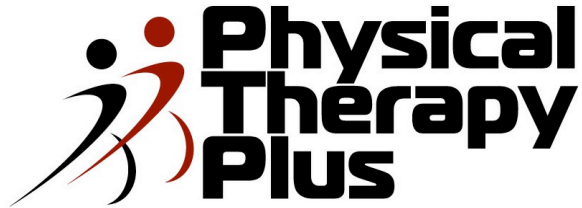
Would you like a complimentary reminder of your appointment?

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