**Start Date:** **Therapist:**

NAME: (Last) ______________________ (First) ____________________ (M.I.) ______

ADDRESS: ____________________ CITY:__________ STATE: _____ ZIP: ________-______

BIRTHDATE: ___/___/_____ SSN : __________________ DL#: ________________SEX: ☐ F ☐ M

PHONE#: Home (_____) ______________ Work (______) __________ Cell (______) __________

EMAIL ADDRESS: ____________________MAY WE SEND EMAILS TO THIS ADDRESS? ☐ Y ☐ N

EMPLOYER: ______________________________ OCCUPATION:____________________

EMPLOYER ADDRESS: __________________________ PHONE#: __________________

IS THIS A WORK INJURY? ☐ Y ☐ N IS THIS THE RESULT OF AN AUTO ACCIDENT? ☐ Y ☐ N

EMERGENCY CONTACT : ________________________PHONE: (____) ______________ ☑

**HOW DID YOU HEAR ABOUT US? MD Returning Patient Family/Friend ________________**

**Other: ______________________________________**

**MEDICARE PATIENTS ONLY**

| | | |
|---|---|---|
| HAVE YOU RECEIVED HOME HEALTH WITHIN THE LAST 2 MONTHS? | ☐ Y | ☐ N |
| ARE YOU CURRENTLY RECEIVING ANY TYPE OF THERAPY AT ANOTHER FACILITY OR HOSPITAL? | ☐ Y | ☐ N |

**MEDICAL INFORMATION (For office use only)**

DIAGNOSIS: ________________________________________ ICD-10#: ______________

REFERRING DOCTOR: ______________________________ DATE OF REFERRAL: __________

DATE OF INJURY: __________________

**INSURANCE INFORMATION: PRIVATE MEDICARE (For office use only)**

**PRIVATE INSURANCE:**__________________________ ID #: ______________________

EFFECTIVE DATE:______________ DEDUCTIBLE: $__________ MET: $___________ COPAY:______

COVERED AT_______% PLAN LIMITATIONS:________________________________________

CONFIRMED BY: ____________________ DATE:___________

**SECONDARY INSURANCE:**

COMPANY: ____________________ ID#: ____________________________________

***PATIENT IS AWARE OF DEDUCTIBLE AND WILL PAY $75 PER VISIT. WE WILL BILL PATIENT ANY DIFFERENCE THAT IS APPLIED TO THE DEDUCTIBLE, AS THIS IS AN ESTIMATE OF CHARGES. PATIENT INITIALS: __________**

I hereby give lifetime authorization for payment or insurance benefits to be made directly to this healthcare provider and/or its affiliates for services rendered. I understand that I am financially responsible for all charges not paid by my insurance company. In the event of default, I agree to pay all costs of collection and reasonable attorney fees, I hereby authorize this health care provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement is as valid as the original. I further authorize that my signature on this form constitutes assignment of benefits to this healthcare provider.

I consent to have this healthcare provider and/or its affiliates provide the treatment and care prescribed by my physician(s). I understand this consent may be revoked by me at any time.

**SIGNATURE:________________________________ DATE: __________________**

## RESPONSIBILITY FOR AMOUNT DUE

Health insurance is designed to help meet the cost of medical services, but basic responsibility for payment is yours. Your insurance contract defines to what extent the services are covered. A mutually agreeable, realistic plan for payment will always be considered if you discuss it with us.

## POLICIES AND PROCEDURES

You are responsible for all co-payments, deductibles, percentages, and any other portion your insurance does not pay. Co-payments, co-insurance, and deductibles are due at time of service. It is your responsibility to call your insurance company and find out your coverage.

If your policy or insurance company changes and you fail to inform us, any visits that may not be authorized or your new insurance company does not cover charges that are incurred, you will be responsible for those charges.

## PATIENT CANCELLATION AND NO SHOW POLICY

**24-Hour notice must be given or you will be subject to a cancellation charge of $50 after the 2nd occurrence.** This charge cannot be billed to your insurance company and will be your responsibility. This charge is due and payable on or before your next appointment.

**If you no-show any appointment there will be an automatic $50 charge.**

Each cancel or "no show" appointment will be noted in your chart. Failure to actively participate in your rehabilitation program may result in the impression that you are disinterested in recovery or are better and able to return to work. Your claim adjustor/case manager will be notified of any failed visits.

Cancellation or failure to attend three (3) consecutive appointments will result in you being discontinued from physical therapy, in addition, your doctor and all appropriate parties will be notified. To restart your therapy, you must return to your physician for a new prescription/referral.

## PATIENT PRIVACY NOTICE

We are required by law to maintain the privacy of your healthcare information, provide you with the attached notice of our legal duties and healthcare information privacy practices, and abide by the terms of this notice.

**By signing, you indicate you have read and understand the contents of this page.**

**Signature:** ______________________________________________ **Date:** _________________________

CAMPUS COMMONS
PHYSICAL THERAPY

# Medical History

**Name:** ________________________________ Date: _____________ Height: _________ Weight: __________

What is the reason for your visit today?_____________________________________________________________

Describe any previous treatment for the condition we are seeing you for today. _________________________________

Have you had any tests for this current problem? (**please circle**): X-Ray MRI CT Scan Lab Work Other:__________

Do you have a previous injury or condition that may affect your treatment? ___________________________________

Have you fallen two times or more in the last year, or had any fall resulting in an injury? YES NO
**YES**, Explain: ___________________________________________________________________________________

**Currently, I am experiencing the following? (Circle all that apply)**

| | | | |
|---|---|---|---|
| Unexplained Weight Loss/Gain | Falls/Loss of Balance | Headaches | Shortness of Breath |
| Loss of Consciousness/Fainting | Changes in appetite | Numbness / Tingling | Dizziness |
| Changes in bowel/bladder function | Nausea / Vomiting | Fever / Chills | Night Sweats |

Please list past surgeries and dates: ______________________________________________________________

_____________________________________________________________________________________________

| | | | |
|---|---|---|---|
| Do you exercise? | YES / NO | Do you wear glasses/contacts? | YES / NO |
| Do you use alcohol? | YES / NO | Are you pregnant? | YES / NO |
| Do you smoke? | YES / NO | Do you have difficulty hearing? | YES / NO |

Please indicate (**X**) if you have or have ever had any of the following:

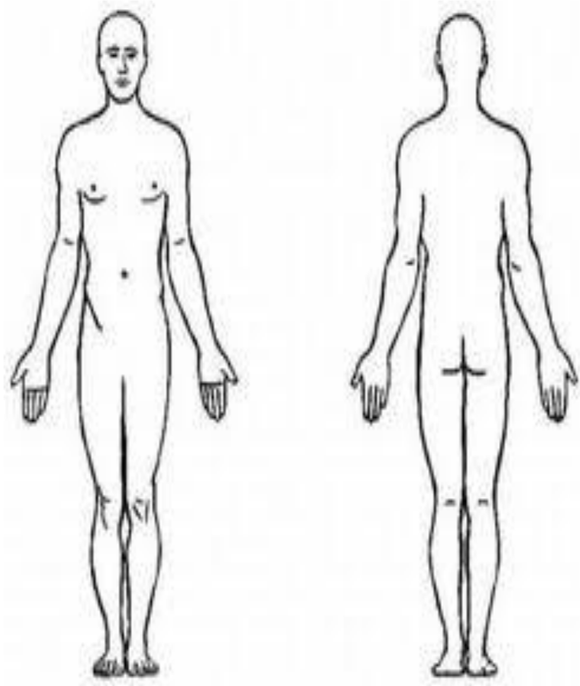
_____ Cancer(type):___________________
_____ Pacemaker/Heart disease
_____ Blood Pressure Problems
_____ Circulation Problems
_____ Asthma/Lung Disease
_____ Stroke
_____ Nervous Disorder
_____ Seizures
_____ Diabetes
_____ Osteoporosis
_____ Kidney Disease
_____ Rheumatoid Arthritis
_____ Other Arthritic Conditions
_____ Allergies
_____ Anemia
_____ Thyroid Problems

Please explain and give approximate dates for any item indicated above: ______________________________________

_____________________________________________

Please indicate on the body chart below the symptoms you are having:

**Numbness/tingling: XXXX** **Burning Pain: OOOO**
**Dull/Aching Pain: ====** **Sharp Pain: ////**



**Please circle the pain intensity when you feel the BEST, and when you feel the WORST (0 = no pain, 10 = worst pain imaginable)**

**Pain at best =** 0 1 2 3 4 5 6 7 8 9 10

**Pain at worst =** 0 1 2 3 4 5 6 7 8 9 10

# Medication List

**Please include prescription, over-the-counter, herbals, and supplements.**

**Please indicate how medication is taken if not taken orally. Thank you!**

Patient Name:________________________________________ Date: ____________________

Patient Signature:______________________________________________________________

☐ No Medications

☐ See attached list

| | Medication: | Dose: | Frequency: |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |
| 7. | | | |
| 8. | | | |
| 9. | | | |
| 10. | | | |
| 11. | | | |
| 12. | | | |
| 13. | | | |