

**Physical Therapy First, L.L.C.  
Patient Information Form (Please Print)**

<b>Patient Information</b>				
Patient Name (Last, First, MI)	Sex	Marital Status	Date of Birth	Social Security No.
Street Address	City, State, Zip			Home Phone
Employer / Employer Address				Work Phone
Email Address				Cell Phone

<b>Guardian Information (Responsible Party)</b>				
Guarantor / Guardian Name	Sex	Relation	Date of Birth	Social Security No.
Street Address	City, State, Zip			Home Phone
Guarantor / Guardian Employer	Employer Address			Work Phone

<b>Other Information</b>
Referring Doctor (Name, Location)
Family Doctor (Name, Location)
Emergency Contact /Relation/ Phone

<b>Primary Health Insurance</b>				
Primary Carrier	Mailing Address			
ID No.	Group No.	Employer		
Policy Holder	Sex	Relation to Patient	Date of Birth	Social Security No.

<b>Secondary Health Insurance</b>				
Secondary Carrier	Mailing Address			
ID No.	Group No.			Employer
Policy Holder	Sex	Relation to Patient		Date of Birth

**If applicable:**

<b>Workman's Compensation</b>		
Carrier Name	Mailing Address	
Claim No.	Date of Accident	Adjuster's Name / Phone No.

<b>Automobile Accident</b>		
Carrier Name	Mailing Address	
Claim No.	Date of Accident	Adjuster's Name / Phone No.

I certify that the above information is correct. I understand that I am personally responsible to pay all charges for services rendered to me and agree to make payment, thereof, when due. Any billing sent by the provider to an insurance company, attorney, or other third party is for the accommodation of the patient and does not relieve the undersigned to pay charges for services provided. If it is determined by the Worker's Compensation Board that the illness or condition is not a result of a compensable Worker's case, I agree to pay Physical Therapy First, LLC for services rendered. I authorize payment for these services be paid directly to Physical Therapy First, LLC.

Signature \_\_\_\_\_ Date \_\_\_\_\_

# Physical Therapy First, LLC.

## CONSENT FOR CARE AND TREATMENT

I the undersigned, having legal authority to do so, do hereby agree and give consent for *Physical Therapy First* to furnish medical care and treatment to \_\_\_\_\_ as considered necessary and proper in diagnosing or treating my/his/her condition.

## BENEFIT ASSIGNMENT / RELEASE OF INFORMATION

I hereby assign all medical benefits, including major medical benefits, Medicare, private insurance and any other health plans to which I am entitled to *Physical Therapy First*. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize the release of all information necessary, including Medical Records, to secure payment.

## FINANCIAL POLICY STATEMENT

*Physical Therapy First* bills your insurance carrier as a courtesy to you, although you are responsible for the entire bill when services are rendered. We require that arrangements for payment of your estimate portion of the bill be made today. This includes co-payments, co-insurance, and deductibles if required by your health insurance carrier. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. If any payment is subsequently made by your insurance carrier in excess of the balance of your account, we will promptly refund the credit.

If any payment is made directly to you for services billed by us, you agree to promptly remit the payment to *Physical Therapy First*.

The above does not apply for those patients covered by the Workers' Compensation Act. However, a Workers' Compensation patient may be responsible for the charges if the claim is denied.

In the event my balances remain unpaid for any reason, I agree to pay a penalty of 30% of the open balance to cover collections agency fees and/or attorney fees in addition to court costs.

## SCHEDULING AND CANCELLATION POLICY

*Physical Therapy First* reserves the right to bill a **\$30** no show fee **if we are not notified** that you are unable to attend your scheduled appointment. If you cannot attend your scheduled appointment time, we ask that you notify us **24 hours** prior to your appointment so we may accommodate other patients. Consistency in treatment is important to your rehabilitation outcome and multiple cancellations may result in termination of your treatment or a loss of desired schedule time.

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient: \_\_\_\_\_

Date: \_\_\_\_\_

Guardian/Responsible Party: \_\_\_\_\_

Date: \_\_\_\_\_

# Physical Therapy First, LLC

## Health History (Please Print)

Patient Name (Last, First, MI)	Age:	Height:	Weight:	Today's Date
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Do you have a pacemaker? Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you smoke? Yes <input type="checkbox"/> No <input type="checkbox"/>	Are you latex sensitive? Yes <input type="checkbox"/> No <input type="checkbox"/>
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**ALLERGIES:**

**MEDICATIONS (include pills, injections and/or skin patches):**

Have you ever taken steroid medications for any medical conditions? Yes  No

Have you ever taken blood thinning or anticoagulant medications for any medical conditions? Yes  No

**SURGERIES, INJURIES, AND HOSPITALIZATIONS:**

**Diagnostic Tests (for example: x-ray, MRI, CT Scan, Bone Scan, blood tests):**

**Treatment received so far for this injury, pain, or problem:**

Occupation, including activities that comprise your work day:

Are you on a work restriction from your doctor? Yes  No  If yes, explain:

Leisure activities, including exercise:

**WOMEN ONLY:** Are you currently pregnant or think you might be pregnant? Yes  No

**Have you RECENTLY experienced any of the following (check all that apply)?**

<input type="checkbox"/> Fatigue	<input type="checkbox"/> Numbness or tingling	<input type="checkbox"/> Constipation
<input type="checkbox"/> Fever/chills/sweats	<input type="checkbox"/> Muscle weakness	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Nausea/vomiting	<input type="checkbox"/> Dizziness/lightheadedness	<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Weight loss/gain	<input type="checkbox"/> Heartburn/indigestion	<input type="checkbox"/> Fainting
<input type="checkbox"/> Difficulty maintaining balance while walking	<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Cough
<input type="checkbox"/> Falls	<input type="checkbox"/> Changes in bowel or bladder function	<input type="checkbox"/> Headaches

**Have you EVER been diagnosed with any of the following conditions (check all that apply)?**

<input type="checkbox"/> AIDS / HIV	<input type="checkbox"/> Depression	<input type="checkbox"/> Thyroid problems
<input type="checkbox"/> Cancer	<input type="checkbox"/> Lung problems	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Heart problems	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Chest pain/angina	<input type="checkbox"/> Asthma	<input type="checkbox"/> Multiple sclerosis
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Rheumatoid arthritis	<input type="checkbox"/> Epilepsy / Seizures
<input type="checkbox"/> Circulation problems	<input type="checkbox"/> Other arthritic condition	<input type="checkbox"/> Eye problem/infection
<input type="checkbox"/> Blood clots	<input type="checkbox"/> Bladder/urinary tract infection	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Stroke	<input type="checkbox"/> Kidney problem/infection	<input type="checkbox"/> Liver problems
<input type="checkbox"/> Anemia	<input type="checkbox"/> Sexually transmitted disease	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Bone or joint infection	<input type="checkbox"/> Pelvic inflammatory disease	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Chemical dependency (i.e., alcoholism, recreational drugs)		

**Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?**

- |  |                                     |   |
|--|-------------------------------------|---|
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Tuberculosis     |
| <input type="checkbox"/> Heart problems      | <input type="checkbox"/> Stroke     | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Depression | <input type="checkbox"/> Blood clots      |

Approximately what date did your symptoms start (include surgery date if applicable)?

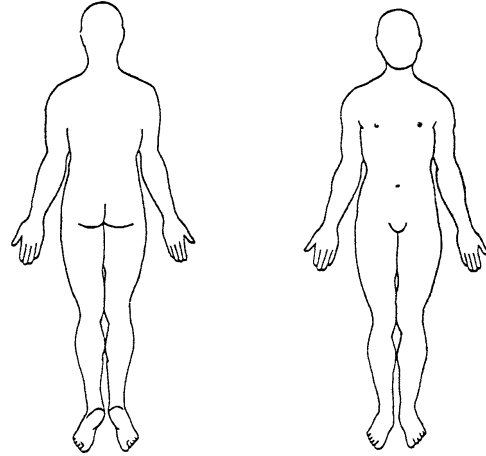
What do you think caused your symptoms, injury and/or pain?

My symptoms are currently:  Getting Better  Getting Worse  Staying about the same

**Body Chart:**

Please mark the areas where you feel symptoms on the chart to the right with the following symbols to describe your symptoms:

- ↓ Shooting/sharp pain  
○ Dull/aching pain  
||| Numbness  
= Tingling



**My symptoms currently:**  Come and go  Are Constant  Are constant, but change with activity

**Aggravating Factors:** Can you identify positions or activities that make your symptoms worse?

1)

2)

3)

**Symptom relieving Factors:** Can you identify positions or activities that make your symptoms better?

1)

2)

3)

**How are you currently able to sleep at night due to your symptoms?**

No problem sleeping  Difficulty falling asleep  Awakened by pain  Sleep only with medication

**When are your symptoms worst?**  Morning  Afternoon  Evening  Night  After exercise

**When are your symptoms the best?**  Morning  Afternoon  Evening  Night  After exercise

**Using the 0 to 10 the scale, with 0 being “no pain” and 10 being the “emergency room pain” please describe:**

Your current level of pain while completing this survey: \_\_\_\_\_

The best your pain has been during the past 24 hours: \_\_\_\_\_

The worst your pain has been during the past 24 hours: \_\_\_\_\_

**Have you ever had this injury before:**  Yes  No **When** \_\_\_\_\_ **Treatment** **rec'd** \_\_\_\_\_