ACTIVE PHYSICAL THERAPY

PATIENT INFORMATION

Patient Name: _____ DOB: _____/_____/_____ SS# _____-_____-_____

Address: _____ City: _____ ST: _____ Zip: _____

Home Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____ Email: _____

Check Appropriate: Minor _____ Single _____ Married _____ Separated _____ Widowed_____ Select One: ☐Male ☐Female

If patient is a full-time student, name of school: _____, City/State: _____

If patient is employed, place of employment: _____, City/ State:_____

How did you hear about us? Physician Referral _____ Close to Home/Work _____ Website _____ Friends/Family _____ Other: _____

Primary Physician: _____ Phone #: (_____) _____-_____

Guarantor/ Spouse/ Parent/ Other Relationship to Patient Information:

Name: _____ Relationship to Patient: _____

DOB: _____/_____/_____ SS#: _____-_____-_____ Phone: (_____) _____-_____

Mailing address: _____ City _____ ST _____ Zip_____

Email address: _____

Emergency Contact Name: _____ Phone: (_____) _____-_____

Insurance Information: Please present all insurance cards to receptionist if haven't already.

Do you have Medicare? Yes _____ No _____

- If **yes** are you currently receiving at home health care? Yes _____ No _____

Insurance company: _____ Subscriber's name: _____

Subscribers relationship to patient: _____ DOB: _____/_____/_____ Group#: _____

Secondary Insurance *if you have NO secondary Insurance initial here (_____)

Insurance Company: _____ Subscribers Name: _____

Subscriber's Relationship to Patient: _____ DOB: ____/_____/_____ Group # _____

AUTHORIZATION AND RELEASES

- I hereby authorize Active Physical Therapy and its staff, to release to the above company(s) or its representatives, to myself, to my primary care or referring physician(s), and to consulting physicians any information used for treatment or payment.
- I authorize payment of benefits directly to Active Physical Therapy. We're networked provider to most insurance companies and will bill your insurance for you. As a courtesy we will contact your insurance provider to verify your PT coverage. We cannot guarantee the accuracy of the information we receive from your insurance provider. Also, if my insurance company forwards payment directly to me, instead of Active Physical Therapy, I'll immediately deliver said payment to Active Physical Therapy. Should the party default, they will be responsible for all reasonable Collection Charges and Attorney fees incurred by the creditor because of recovery efforts to collect the debt. The Collection charges result from the cost associated with 3rd Party recovery.
- The signature below acknowledges receipt or offering of a copy of Active Physical Therapy's notice of Privacy Practice.
- I hereby consent to and authorize all therapy treatments, which in conjunction with the judgment of my attending provider, may be considered necessary and/ or advisable for the diagnosis and/ or treatment of the patient named above.
- By signing this Authorization, I agree that this office, and any third party used for treatment, billing, collection and other services, may use any means of communication with me. Thus, I understand and agree that any phone numbers and email addresses provided by myself to this office may be used to contact me, and that this office may leave messages for me manually.

Signature: _____ **Date:** _____

(Parent or Guardian must sign if patient is under 19 years of age)

Medical History

Accident/Workers Compensation Injury Information ***(if any pertains to your condition ask receptionist for separate form for more details)***

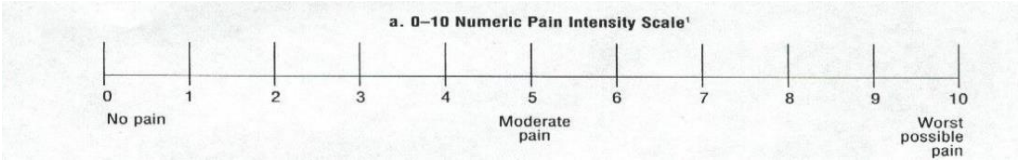
How were you injured? Work related? Y / N Sports injury? Y / N Motor Vehicle Accident? Y / N

Other: _____

Existing or Relevant Previous Conditions

Allergies	◯ Yes ◯ No	Dizzy Spells	◯ Yes ◯ No	MRSA	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Emphysema/Bronchitis	◯ Yes ◯ No	Multiple Sclerosis	◯ Yes ◯ No
Anxiety	◯ Yes ◯ No	Fibromyalgia	◯ Yes ◯ No	Muscular Disease	◯ Yes ◯ No
Arthritis	◯ Yes ◯ No	Fractures	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Gallbladder Problems	◯ Yes ◯ No	Parkinson's	◯ Yes ◯ No
Autoimmune Disorder	◯ Yes ◯ No	Headaches	◯ Yes ◯ No	Rheumatoid Arthritis	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Hearing Impairment	◯ Yes ◯ No	Seizures	◯ Yes ◯ No
Cardiac Conditions	◯ Yes ◯ No	Hepatitis	◯ Yes ◯ No	Smoking	◯ Yes ◯ No
Cardiac Pacemaker	◯ Yes ◯ No	High/Low blood pressure	◯ Yes ◯ No	Speech Problems	◯ Yes ◯ No
Chemical Dependency	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Strokes	◯ Yes ◯ No
Circulation Problems	◯ Yes ◯ No	HIV/AIDS	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Currently pregnant	◯ Yes ◯ No	Incontinence	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Depression	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Vision Problems	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Metal Implants	◯ Yes ◯ No		

(Please indicate your level of pain on the scale below, 0 being none and 10 being worst possible)



Fall History

o Injury because of a fall in the past **Two or more falls in the last year? _____** **Date of injury or onset: _____**

Surgical History

Body region: _____Surgery type: _____Date _____/_____/_____

Body region: _____Surgery type: _____Date _____/_____/_____

Body region: _____Surgery type: _____Date _____/_____/_____

Current Medications ◯ Currently not taking medications ◯ May provide list of medications

Drug: _____Dosage: _____Frequency: _____ Route: _____ Reason taking: _____

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PATIENT MISSED APPOINTMENT POLICY

We strive to provide our patients with the utmost professionalism and excellence of service. Our Commitment to your wellbeing and gain of your physical abilities is something everyone in our clinic takes quite seriously.

Because we care so much about you we realize it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need to receive and to the actions we ask you to do. Your adherence to the recommended number of treatments is a vital component of your progress with our services; therefore, we have certain rules that need to be followed to ensure the most optimum results.

We expect you to keep all your appointments. We write down the time of your visits on an appointment card or calendar for you, so you do not forget.

Except for serious emergencies it is expected that you keep all your appointments. IF you need to reschedule an appointment we require **24-hour notice**. In such case, please call our office and arrange for a make-up appointment with our Front Desk Receptionist. The make-up appointment needs to be in the same week, preferably the next day.

IN an instance of a cancellation without 24-hour notice or no-show to a scheduled appointment, we reserve the right to charge you a **$35 no show fee.**

In instances of repeated non-compliance with your scheduled visits, we also reserve the right to discontinue care and will inform your physician of the fact that your service has been discontinued due to non-compliance with the prescribed rehabilitation order.

We appreciate you greatly as our patient and strive to accomplish wonderful results and success for you.
All the staff at Active Physical Therapy.

I have read and understand this policy.

Patient Name	**Signature**	**Date**

Name of Parent/Legal Guardian	**Signature**	**Date**

PATIENT FINANCIAL POLICES

TO OUR VALUED PATIENTS:

We are committed to providing you with the best possible care. If you have medical insurance, we are eager to help you receive your maximum, allowable benefits. To do this, we need your assistance and understanding of our payment policy. Also note, our company complies with all HIPAA Privacy Practices. By signing this form, you acknowledge that you have been offered and/ or received a list of these practices.

Please read carefully:

1. Your insurance is a contract between you, your employer and your insurance company. We are not a party to that contract. You will be responsible for paying for your visits until your deductible is met. Once your deductible is met, you will be responsible for your co-pay or co-insurance.
2. Our fees are considered to fall within the acceptable range by most companies and are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage of U.C.R. "U.C.R." is defined as usual, customary and reasonable by most companies. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees.
3. Not all services are in all contracts. Some insurance companies select certain services they will not cover. *These services, if any, are your responsibility*. We will make our best attempts to inform you as soon as possible if/ when we encounter services your insurance company does not cover. If your insurance company does not cover supplies, you would be responsible for payment of such, should you choose to receive them.
4. **The estimate provided at time of service is not an exact calculation of your actual costs and does not reflect all the terms, conditions, limitations, and exclusions that may apply to your coverage. Your actual costs will vary depending upon the specifics of your benefit plan and the services and supplies you receive.**
5. If this injury is work related and a Workers Compensation claim has been initiated then we require, on our initial visit that you provide us with a claim # to ensure payment on the account.
6. For liability cases, when another party is responsible, you need to provide us with all the billing information. If you have an attorney, please provide this information on the registration form.
7. Our office requires a **24-hour notice for cancellation of appointments**. We realize conflicts with work, other activities, or unexpected illness may require you to call and reschedule, however, there may be a **$35.00** charge for a missed appointment without notification to the office.
8. Payment is due at time of service unless you have signed a monthly payment contract. Any account that goes beyond our 6-month maximum allowance time for payment in full will be assessed a 5% finance charge per month (minimum $2.00/ month) against any unpaid balance. Payments made on an account will be applied to the oldest outstanding balance first.
9. We reserve the right to terminate services if payments are not made in a timely fashion.

Again, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are patient responsibility from the date the services are rendered. Should you encounter a problem making payments on time, we encourage you to contact us promptly for assistance in setting up a payment plan. If we do not receive payment from you according to agreement and or/ arranged payment plan notice we sent to you, you agree to be responsible for any expenses incurred in collecting patient's account, including all fees, court costs, attorney fees, and all other collection related expenses. By signing below, patient/responsible party acknowledges that he/she has read, understand and herby accepts the above obligations and agreements. ***If you have any questions about the above information or any uncertainty regarding insurance coverage, please don't hesitate to ask us. We are here to help you!***

I have read the above polices and agree.

_____

Patient name (Print) ***Signature*** ***Date***

_____

Parent or legal guardian Name (Print) ***Signature*** ***Date***