

WELCOME!!

Date_____/_____/_____

Patient Information

Name _____

Last First Middle

Street Address _____

City, State, ZIP _____

Phone # (home)_____ (work)_____ (cell)_____

Can we call you at work? ☐ Yes ☐ No DOB____/____/____ Age_____ Sex: ☐ Female ☐ Male

E-Mail Address : _____

Who is your cellphone provider? We send text message reminders. _____

Occupation: _____ Employer _____

How did you hear about our practice? _____

Emergency contact: _____ Relation: _____

Emergency contact phone #: Primary _____

Financial Information

Name of person responsible for this account: _____

Relationship to patient (if other than self) _____

How many insurance policies are you covered under (job/self/parent/spouse/secondary/supplemental): _____

1. Insurance _____

2. Insurance _____

3. Insurance _____

*Please Provide This Office With A Copy of Your Insurance Card (s) and Drivers License

Assignment and Release (insured patients)

I certify that I (or my dependent) have insurance with _____
And I AUTHORIZE, REQUEST, AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO JONES
PT: PHYSICAL THERAPY AND PHYSICAL TRAINING INSURANCE BENEFITS OTHERWISE PAYABLE
TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby
authorize the physical therapist to release all information necessary, including diagnosis and the records of any exams
or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all
insurance claims, including electronic submissions:

SIGNATURE (x) _____ DATE ____/____/____

Patient Name: _____

Consent to Care

A patient coming to the physical therapist gives him/her permission and authority to care for the patient in accordance with appropriate test; diagnosis; and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies; may render the patient susceptible for injury. The physical therapist, of course, will not provide specific health care, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the physical therapist.

Protected Health Information

Purpose: This notice HIPAA ([Health Insurance Portability and Accountability Act](#)) is U.S. legislation that sets national standards for protecting individuals' sensitive health information, known as [protected health information](#) (PHI). It gives patients' rights to their information, requires healthcare entities to secure this data through administrative, physical, and technical safeguards, and places limits on its use and disclosure without patient consent.

Missed Appointment Policy

We appreciate having you as a patient and are committed to helping you achieve optimal results. Your adherence to the recommended number of treatments is a vital component of your progress in physical therapy.

With the exception of emergencies, it is expected that you keep all of your scheduled appointments. If you are unable to keep a scheduled appointment, please call our office to reschedule. If you need to call after hours, please leave a message on the answering machine. We kindly ask for **24 hours advanced notice**. We reserve the right to charge a **\$25 no-show fee** for a missed appointment.

In instances of repeated non-compliance with scheduled appointments, we reserve the right to discontinue care. We will inform your prescribing physician/Worker Compensation adjuster that your physical therapy service has been discontinued due to non-compliance with the prescribed rehabilitation order.

I have read and understand the foregoing (Consent to Care, HIPPA, and Missed Appointment Policies).

Patient's/Guardian Signature _____ Date ____/____/____

Financial Office Policies

1. All patients are on a cash basis until our staff may verify all insurance coverage(s).
2. Provide all insurance policies to ensure timely filling. If you have multiple policies you must disclose all of them in order for proper billing and to avoid personal charges.
3. If you change your insurance provider you must notify the front desk and provide the new insurance information.
4. If you add another insurance policy, you agree to provide this front desk with the current information immediately.
5. Your insurance will be verified promptly and will be reviewed with you if applicable.
6. If the deductible has not been met, you will be on a cash basis until such time that the deductible has been met.
7. After coverage and deductible are verified, this office may accept assignment on most policies provided the insured/patient signs an appropriate statement of benefit and or lien authorizing payments to be sent to the provider.
8. Waiting for the insurance payment is a courtesy and it may be withdrawn under certain circumstances.
9. As a patient, it is your responsibility to take care of the co-insurance or co-payment (usually a percent or fixed dollar amount) and any non-covered services on a weekly basis. Any such plan or arrangements will be discussed during your scheduling phone call or in the beginning of your first visit.
10. This office does not warrant or guarantee that your insurance will pay, nor does this office promise that an insurance company will or should pay the fees charged. Insurance policies are an arrangement between the insurance carrier and the patient insured.
11. Any services not covered or coverage reduction by your insurance will be the patient's responsibility.
12. This office will submit an insurance claim one time. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly with your insurance adjuster or agent. Any denied or disputed claims will be treated as uncovered.
13. If your account should go to collection for any reason, it will be the patient's responsibility for any court cost, attorney fees, and/or collection cost incurred in collecting the account balance.
14. I authorize the release of any medical or other records or information necessary to process any claims from this office.
15. All insurance payments are applied to your account as long as any balance is due, regardless of which company issues a check first. This means refunds are made only after your balance is completed and cleared with this office.
16. If you receive correspondence of checks from your insurance company, you agree to bring these into our office so that we may determine if any action needs to be taken or if the check is on assignment to this office.
17. This office accepts personal check, cash and credit card.
18. If you have any questions concerning this or any other matter, please speak with the front desk person prior to seeing the physical therapist.
19. Please be advised that copies of medical records will be **\$15.00 to \$20.00**.

Thank you for your cooperation on this matter.

I have read and fully understand the financial office policy and agree to abide by these terms.

Patient Signature (or Responsible Party)

_____/_____/_____
Date

****Note:** To fill-in the "x" for YES or NO - right click your mouse and scroll down and click "add text" and this will allow you to make your "x" on the appropriate line. **



REVIEW OF SYSTEMS

Have you had or do you experience?

YES	NO	Cardiovascular System	G.I. System	YES	NO
___	___	Elevated cholesterol	Difficulty swallowing	___	___
___	___	Sweating associated with pain	Heartburn	___	___
___	___	Palpitations	Jaundice (yellow appearance)	___	___
___	___	Swelling of extremities	Specific food intolerance	___	___
___	___	History of smoking	Constipation	___	___
___	___	Orthopnea (difficulty breathing)	Diarrhea	___	___
___	___	Pacemaker	Change in color of stool	___	___
___	___	Hypertension	Rectal bleeding	___	___
			Gall bladder problems	___	___
			Liver problems	___	___

YES	NO	G.U. System	Pulmonary System	YES	NO
___	___	Dysuria (painful urination)	Dyspnea (labored breathing)	___	___
___	___	Hematuria (blood in urine)	Wheezing	___	___
___	___	Incontinence	Prolonged cough	___	___
___	___	Frequency of urination	Sputum production	___	___
___	___	Urinary urgency	Amount/Color:		
___	___	Post menopausal vaginal bleeding	_____		

YES	NO	Neurological System	Endocrine System	YES	NO
___	___	Ataxia (poor muscle coordination)	Excessive thirst	___	___
___	___	Memory lapses	Excessive hunger	___	___
___	___	Confusion	Polyuria (large volume of urine)	___	___
___	___	Head Trauma	Excessive sweating	___	___
___	___	Neurological disorder	Fatigue	___	___
___	___	Tremors	Weakness	___	___
___	___	Slurred speech patterns	Thyroid problems	___	___
___	___	Hearing/Visual disturbances			

YES	NO	Other Systems	YES	NO
___	___	ENT (ears, nose, throat)	___	___
___	___	Integumentary (skin)	___	___
___	___	Lymphatic	___	___
___	___	Psychiatric	___	___
___	___	Musculoskeletal	___	___
___	___	Cancer	___	___
		Type: _____		