PHYSICAL THERAPY PROFESSIONALS PC
PATIENT INFORMATION/AUTHORIZATION TO TREAT

PATIENTS NAME_____ DATE OF BIRTH_____ AGE _____

STREET ADDRESS_____

CITY_____ STATE _____ ZIP_____

HOME PHONE (_____)_____CELL PHONE (_____)_____ SEX: M / F

E-MAIL _____ PATIENT SSN_____-_____-_____

PATIENT EMPLOYER_____

OCCUPATION_____ WORK PHONE (____) _____

REFERRING PHYSICIAN_____ PRIMARY PHYSICIAN_____

HOW DID YOU HEAR ABOUT US _____

PERSON TO CONTACT IN CASE OF EMERGENCY RELATIONSHIP_____

FIRST AND LAST NAME_____PHONE (_____) _____

****IF PATIENT IS A MINOR PLEASE PROVIDE US WITH THE FOLLOWING INFORMATION**:

PARENT/GUARDIAN NAME_____ SSN_____-_____-_____

PARENT/GUARDIAN EMPLOYER_____ WORK PHONE (_____) _____

COMPLETE FOLLOWING IF YOUR INJURY WAS DUE TO MOTOR VEHICLE ACCIDENT:

NAME OF VEHICLE INSURANCE_____ PHONE (_____) _____

ADJUSTER NAME _____PHONE (_____) _____

ACCIDENT CLAIM#_____

****PLEASE INITIAL THE FOLLOWING:**

_____ **I HEREBY AUTHORIZE PHYSICAL THERAPY PROFESSIONALS TO PROVIDE TREATMENT AS PRESCRIBED BY MY PHYSICIAN.**

_____ **I HEREBY ASSIGN ALL INSURANCE BENEFITS FOR SERVICES RENDERED TO BE PAID DIRECTLY TO PHYSICAL THERAPY PROFESSIONALS.**

_____ **I UNDERSTAND THAT IF MY INSURANCE CO/THIRD PARTY PAYER DENIES PAYMENT OR MAKES PARTIAL PAYMENT I AM RESPONSIBLE FOR THE BALANCE DUE.**

_____ **I HEREBY AUTHORIZE THE RELEASE OF MEDICAL RECORDS TO PHYSICAL THERAPY PROFESSIONALS AND ANY PERTINENT INFORMATION CONCERNING THE PATIENT FOR THE PROVISION OF CARE AND FOR OBTAINING INSURANCE REIMBURSEMENT.**

_____ **I UNDERSTAND THAT I AM LEGALLY RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED BY PHYSICAL THERAPY PROFESSIONALS. INSURANCE IS BEING BILLED AS A COURTESY. I AM RESPONSIBLE FOR PAYING ANY DEDUCTIBLE OR CO-INSURANCE AMOUNTS. I UNDERSTAND THAT CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE.**

PHYSICAL THERAPY PROFESSIONALS, PC
PATIENT MEDICAL HISTORY

NAME: _____ DATE OF NEXT MD APPOINTMENT: _____

Describe briefly the history of your present ILLNESS OR CONDITION for which you are here:
Onset Date: _____ Description: _____
_____
_____

Please list any special concerns, questions or expectations: _____
_____

Have you **fallen** in the past year? _____ If so, how many times? _____ If so, did you sustain an injury?_____

Have you had <u>any physical therapy</u> during the current calendar year? _____ Have you had any treatment for the same condition for which you are here today? _____ If yes, please indicate what kind:
_____

List **<u>ALL</u> medications** you are currently taking (if you have a list we will copy it): _____
_____
_____

Please list **<u>ALL</u> allergies** here: _____

What is your weight: _____ What is your height: _____

Do you have **METAL IMPLANTS** anywhere in your body such as pins/plates, pacemaker, stints, etc.?
Describe: _____

Please list **<u>ALL</u> surgeries** you have had (last 10 years); please give procedures and dates, if possible: _____
_____
_____

Have you ever had: (Please circle yes or no)

High blood pressure	Yes	No	Arthritis/Osteoarthritis	Yes	No
Heart disorders	Yes	No	Osteoporosis	Yes	No
High Cholesterol	Yes	No	Cancer	Yes	No
Lung Disorders	Yes	No	Pacemaker	Yes	No
Circulation disorders	Yes	No	Are you pregnant?	Yes	No
Dizzy Spells	Yes	No	Allergies to tapes or lotions?	Yes	No
Seizures	Yes	No	Tobacco use	Yes	No
Diabetes	Yes	No			

_____
_____

SIGNATURE: _____ DATE:_____

Physical Therapy Professionals(PTP)

CANCELLATION AND NO-SHOW POLICY

PTP RESERVES THE RIGHT TO DISCHARGE *ANY* PATIENT WITH FREQUENT MISSED VISITS

Cancellation: an unfulfilled appointment where the patient calls the office to notify the staff ahead of time.

No-Show: an unfulfilled appointment where the patient fails to notify the office staff ahead of time.

Physical Therapy Professionals books specific slots of time for you and for all our patients allowing everyone to receive the utmost personal care and attention. Late cancellations and no-shows greatly impair our ability to provide the best care possible to our patients. It also slows each patient's rehabilitation progress and eliminates a treatment appointment that could have been used by another patient.

PTP requires patients to allow a courtesy of 24 hours notification for *all* cancellations.

PTP reserves the right to charge you *$25.00* for a *cancellation* within 24 hours prior to your scheduled appointment.

PTP reserves the right to charge you *$50.00* for all *no-shows* as well as removing all future appointments and discharging you from our care.

PTP requests that you adhere to this policy so that we may offer readily available appointments for you and for all our patients.

Patients Signature:_____Date:____/____/_____

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