PLEASE PRINT TODAY'S DATE:

PATIENT INFORMATION

LAST NAME________________________________ FIRST______________________________MI_____________ AGE__________________

ADDRESS____APT____CITY_________________________ STATE_____ZIP__________

E-MAIL____ HOME PH_______________________ CELL PH______________________________

OCCUPATION______________________________ EMPLOYER/SCHOOL__________________________________ WORK PH_______________

SOCIAL SECURITY NO___________________________ SEX: M / F DATE OF BIRTH ____________ MARITAL STATUS: S / M / D / W

EMERGENCY CONTACT (Name)________________________________ PHONE________________RELATIONSHIP_______________________

INSURANCE INFORMATION

RESPONSIBLE PARTY (If under 19 years)____PH________________________

ADDRESS____APT____CITY_____________________________STATE_____ZIP_______

PRIMARY INSURANCE COVERAGE
INSURANCE COMPANY ____PH________________________

SUBSCRIBER NAME____SS# _______________________ DATE OF BIRTH________________

RELATIONSHIP TO PATIENT_________________________ POLICY ID#______________________ GROUP #__________________________

SECONDARY INSURANCE COVERAGE
INSURANCE COMPANY ____PH________________________

SUBSCRIBER NAME____SS# ________________________ DATE OF BIRTH_______________

RELATIONSHIP TO PATIENT_________________________ POLICY ID#________________________ GROUP #_________________________

Assignment of insurance benefits, release of information and authorization for treatment, responsibility for payment, and medical release:

I authorize PT Solutions to provide physical therapy treatment, tests and procedures considered advisable by my physician. I, the undersigned, do hereby expressly guarantee payment in full of any and all claims and charges in consideration for medical services rendered by PT Solutions. I hereby authorize and demand the assignment of my basic medical, major medical, auto medical, third party medical or any other medical benefits that my apply, herein specified and otherwise payable to me, directly to PT Solutions. I authorize PT Solutions to release medical information acquired in the course of my treatment and examination to my insurance company and to my physicians. If for any reason the account should become delinquent, I agree to pay all rebilling charges, costs related to collection efforts, and reasonable legal fees. I have read and understand the policies as mentioned above.

____

SIGNATURE OF PATIENT, GUARDIAN OR AUTHORIZED REPRESENTATIVE DATE SIGNED

CURRENT INJURY / DISORDER INFORMATION

REFERRING DOCTOR:____________________ TYPE OF INJURY/DISORDER/CONCERN ____

IS THIS INJURY RELATED TO: WORK / AUTO / SCHOOL SPORTS / RECREATIONAL SPORTS / OTHER

PLEASE DESCRIBE HOW AND WHEN INJURY/DISORDER OCCURRED____

PLEASE ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR PAIN/SYMPTOMS:

MY PAIN IS WORSE IN THE: MORNING / EVENING / SAME / FLUCTUATES / IN CONSTANT PAIN

PLEASE LIST ANY ACTIVITIES THAT INCREASE YOUR PAIN/SYMPTOMS:

PLEASE LIST ANY ACTIVITIES THAT DECREASE YOUR PAIN/SYMPTOMS?

WHAT IS YOUR LEVEL OF PAIN RIGHT NOW?
NO PAIN 1 2 3 4 5 6 7 8 9 10 WORST PAIN EVER

******ARE YOU CURRENTLY RECEIVING OR HAVE YOU RECEIVED HOME HEALTH CARE WITHIN PAST 60 DAYS?**

YES/NO If yes, what dates did you receive services?__________________________ COMPANY NAME?__________________________________

*******HAVE YOU RECEIVED PHYSICAL THERAPY WITHIN THE CALENDAR YEAR?** YES/NO

HOW DID YOU HEAR ABOUT PT SOLUTIONS?

_____ Physician _____ Web site/Advertisement _____ Friend/Family/Co-worker _____ Insurance company

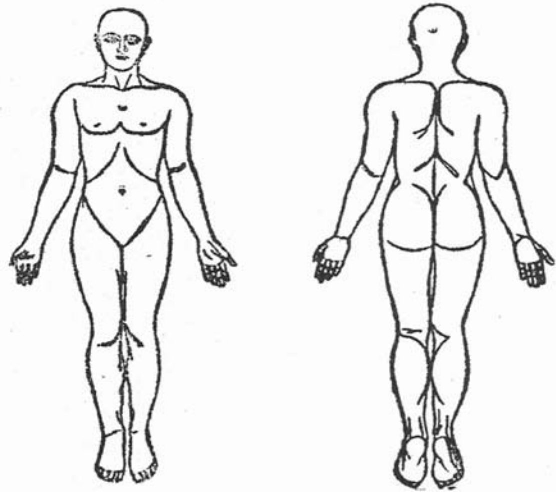
_____ Coach/ Athletic Trainer _____ Other ________________________ Who may we thank for referring you?__________________________

Describe your pain. Use all that apply.

☐ Sharp ☐ Dull ☐ Tingling ☐ Tight
☐ Shooting ☐ Throbbing ☐ Numb ☐ Pulling
☐ Burning ☐ Ache ☐ Heavy ☐ Stabbing

Describe the behavior of your symptoms. Use all that apply.

☐ Constant (Never goes away)
☐ Intermittent (relieved with some positions or rest)
☐ Occasionally (Daily or less frequent)
☐ Infrequently (once a week or month)
☐ Previously (No longer present)
☐ Variable (Sometimes worse than other times)



CIRCLE AREA OF PAIN ON THE DIAGRAM

PRIVACY NOTICE

I, the undersigned, do hereby acknowledge that I have been made aware of the legal duties and policies and procedures of PT Solutions regarding the protection of my personal health information. I understand and agree that, unless I request otherwise in writing, PT Solutions will communicate with me via phone, fax, and e-mail and will state the company name when leaving messages for me via any of these means. Additionally, I have been informed of the company name and I am aware of how I may contact the Privacy Officer should I have questions or comments regarding the privacy practices of PT Solutions.

____

SIGNATURE OF PATIENT, GUARDIAN OR AUTHORIZED REPRESENTATIVE DATE SIGNED

MEDICAL HISTORY SCREENING FORM

Patient Signature: ________________________________

Date of Completion: ____________

To best serve your needs and understand your medical condition – please complete the following. Thank you for your patience.

Please circle yes or no and list where appropriate:

Have you or any immediate family member ever been told you have or are you aware of symptoms related to	**Patient**		**Family**	
Cancer?	Yes	No	Yes	No
Diabetes?	Yes	No	Yes	No
High blood pressure?	Yes	No	Yes	No
Heart disease/Heart attack?	Yes	No	Yes	No
Angina/Chest pain?	Yes	No	Yes	No
Stroke?	Yes	No	Yes	No
Osteoporosis or Osteopenia?	Yes	No	Yes	No
Osteoarthritis?	Yes	No	Yes	No
Rheumatoid arthritis?	Yes	No	Yes	No
Other?___________________________________	Yes	No	Yes	No

Do you have a history of:						
Allergies/Asthma?	Yes	No	Are you under stress?	Yes	No	
Headaches?	Yes	No	Are your symptoms getting	Worse	The same	Improve
Bronchitis?	Yes	No	How are you able to sleep?	Fine	Moderate	Medicate
Kidney disease/problems?	Yes	No	Do you have a problem with	Vision	Hearing	Speech
Rheumatic fever?	Yes	No	How do you learn best?	Seeing	Doing	Hearing
Ulcers?	Yes	No	Do you drink alcohol?	Yes _____/week		No
Sexually transmitted disease?	Yes	No	Do you or have you smoked?	Yes _Packs/Day __Yrs		No
Seizures?	Yes	No	Describe your activity level	Minimal	Moderate	High
Nervous disorders?	Yes	No	Date of last medical examination	__________/___________/________		
Hernia?	Yes	No	**List of Medications you currently use:**			
Metal implants?	Yes	No				
Pacemaker?	Yes	No				
Dizziness/Balance problems?	Yes	No				
Are you pregnant?	Yes	No				
Sensitive to heat/ice?	Yes	No				
Are you depressed?	Yes	No				

In the past 3 months, have you had or did you experience:		
A change in your health?	Yes	No
Nausea/vomiting?	Yes	No
Fever/chills/sweats?	Yes	No
Unexplained weight change?	Yes	No
Numbness or tingling?	Yes	No
Changes in appetite?	Yes	No
Difficulty swallowing?	Yes	No
Changes in bowel or bladder dysfunction?	Yes	No
Shortness of breath?	Yes	No
Dizziness?	Yes	No
Upper respiratory infection?	Yes	No

PT's initials: _________________

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Welcome to PT Solutions!

Please take a minute to review our financial policies, which are designed to clarify your billing and payment questions and assist us in serving you.

- For your convenience, we will verify your insurance benefits and make our best effort to inform you of any services that your insurance may not cover.

- We will file for you all insurance claims for services rendered, and make every effort to obtain reimbursement. However, you are ultimately responsible for insuring we are appropriately reimbursed for the charges incurred during the course of your treatment.

- Any unmet deductible and co-insurance amounts, according to your insurance benefits, will be collected at the time of service.

- Should your insurance company decline to pay for rendered services or should there be any remaining balance that is your responsibility, our billing office will forward a statement to you.

- At PT Solutions, we are dedicated to providing the best possible service for you. If you have any questions or concerns, please feel free to contact our Office Manager.

Please note the following policies pertaining more specifically to your insurance coverage.

Private and Commercial Insurance Billing and Payment Policies:

- Physical Therapy is usually covered under the major medical portion of most commercial insurance policies. Therefore, your insurance carrier may hold you responsible for a major medical deductible and coinsurance portion of the services you receive.
- We will verify all benefits and inform you of those services your insurance carrier may not cover.
- Based on the information provided by your insurance company during insurance verification, we will estimate the portion of charges for which you should be responsible, taking into consideration coordination of benefits, should you have coverage under multiple insurance policies.
- If you insurance company requires prior authorization or precertification for treatment, we ask that you play a proactive part in insurance that all visits are properly pre-approved.
- In the event that your insurance company considers our services to be “out of network,” we will make every effort to accommodate their requirements and will work with you to ensure that you receive your necessary care.

Your insurance benefits are: Deductible (Unmet portion): $__________________

Copay: $_______________ per visit Coinsurance: ________________% per visit

☐ **Medicare Billing and Payment Policies:**

- Medicare covers our services under the Part B, major medical portion of your policy. Therefore, if you do not have a supplemental insurance policy, you will be responsible for satisfying your deductible and 20% of all Medicare allowed fees and we ask that you pay any applicable deductible and co-insurance amounts at each visit.
- We will inform you of any charges which we anticipate Medicare may not cover and ask that you pay for these services when rendered

☐ **Worker's Compensation Requrements and Payment Policies:**

- It is ultimately your responsibility to adhere to all conditions and policies set forth by your employer's workers compensation carrier to insure they will pay for our services, including but not limited to utilizing specific approved care providers and obtaining prior authorization for treatment.
- Most workers compensation carriers require prior approval/precertification before services are provided. We ask that you confirm that each visit has been approved prior to your visit.
- In the event that your employer denies responsibility for your injury or you do not adhere to your employer's guidelines, you will be responsible for the charges that are incurred during the duration of your treatment.
- Please notify us immediately if it is determined that your employer will not be covering your injury, so we can discuss alternatives, such as billing your private health insurance. Our office is willing to work with you and coordinate with your health insurance company to insure that you receive the maximum benefits, as outlined in your policy.

☐ **Auto Insurance/ Accident Billing and Payment Policies:**

- If your injury is a result of an auto or other accident for which a third party may be liable, the insurance for the other party likely will not agree to pay us until you have achieved your maximum recovery sign documentation releasing the third party from any further liability. Therefore, we can not wait for this reimbursement.
- We will bill your personal auto or liability insurance, if indicated, as your primary payer, and we will then bill your personal health insurance. You will be asked to pay any deductibles and coinsurance portion at the time of service.
- If you retain an attorney to assist with reimbursement for this injury, please forward your attorney's name and phone number to us as soon as possible.

If you have any questions of concerns about our billing and payment policies, please feel free to ask our office staff. We are here to assist.

I have read and understand these billing and payment policies and my responsibilities in order to ensure appropriate reimbursement for the services I receive.

Signature ______________________________________ **Date** _________________