PREMIER
PHYSICAL THERAPY

HEALING. SKILL. RESULTS.

Patient Information Form

First Name: _____ Middle Initial: _____ Last Name: _____

Nickname (if applicable): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Social Security #: _____-_____-____ Gender: □ M □ F Age_____ Date of Birth: ____-_____-_____

Primary Phone: _____ Secondary Phone:_____

Work Phone: _____ Would you like appointment reminders: YES or NO
(If selected no appointment reminder cancellation policy still applies)
Email Address:_____

Employer: _____ Occupation: _____

Employment Status: □ Full time □ Part Time □ Retired □ Not Employed

How did you hear about Premier Physical Therapy? (Please mark all that apply)
□Physician referral □ Friend/family: _____ □Radio □Former Patient □Website
□Physical Location □Television □Mail □ Employee at Premier _____

Referring Doctor: _____ Next Dr. Appointment: _____

Primary Family Doctor: _____

In Case of Emergency
If patient is a minor please list both parent's names and phone numbers.
Name of Local Friend or Relative: _____
Relationship to Patient: _____
Cell Phone: _____ Work Phone: _____

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MEDICAL HISTORY FORM

Date of current episode of symptoms/injury/illness: _____

Have you ever had physical therapy before? ☐ Y ☐ N For this condition? ☐ Y☐ N

If yes, where? _____ When? _____

Have you ever had any of the following? ☐X-ray ☐Bone Scan ☐CT ☐ MRI ☐ Myelogram ☐

HEART DISEASE	Yes	No
Heart Attack	☐	☐
Do you have a pacemaker?	☐	☐
	☐	☐

LUNGS	Yes	No
Asthma	☐	☐
Emphysema	☐	☐
COPD	☐	☐
Shortness of Breath	☐	☐

BLOOD PRESSURE	Yes	No
Hypertension	☐	☐
Low Blood Pressure	☐	☐

OTHER CONDITIONS	Yes	No
Rheumatoid Arthritis	☐	☐
Epilepsy	☐	☐
Fibromyalgia	☐	☐
Diabetes	☐	☐
Fainting	☐	☐
Other: _____		
_____		
_____		
_____		
_____		
_____		
_____		

For this condition? ☐X-ray ☐Bone Scan ☐CT ☐ MRI ☐ Myelogram ☐

Have you had any surgeries related to this episode? ☐ Yes ☐ No

If yes, please list: _____

Please list your medications below (if you have a list, please give it to the front desk to copy):

_____

_____

_____

Are you allergic to any medications? Yes___ No___ If yes, what? _____

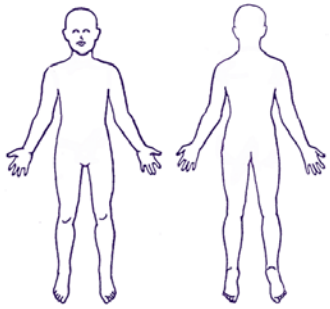
My chief complaint is: _____ Date of onset: _____

How does your complaint limit you (household duties, childcare, recreational activities, etc)?:

_____

_____

_____



Please indicate on the figure above the location of your current complaints.

Please circle on the scale below to indicate your CURRENT level of pain.

No pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it gets

Please circle on the scale below to indicate your WORST level of pain.

No pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it gets

X X

Patient/ Guardian Signature Date

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Liability Financial Policy

In an effort to keep our charges at a minimum, while providing the highest quality of care that this practice is known for, the following policy had to be implemented:

#1 If you have **Health Insurance** we can file the charges to your health insurance. You will be responsible for any co-pay or % that your health insurance does not cover. All copays are collected on the date of service.

#2 If you have **Work Comp** insurance.

#**3** If you have **Medicare.**

#4 If your treatment is due to an **Auto Accident** we can file it though your auto insurance carrier, but we must run it through your primary insurance first. This is acceptable if the auto insurance will be paying the claim as it accrues and not delay payment until the case is settled. If your health insurance paid part or all of your claims and your auto case settles then we will refund your health insurance and you if you made any payments to Premier Physical Therapy.

#5 If you have **No Insurance**(self pay), payment is due time of service. This can be paid by cash, check, VISA or Master Card. Our self pay rate is $100 per visit.

I hereby authorize **Premier Physical Therapy** to furnish information to the insurance carriers concerning my treatment and hereby assign to the therapist all payment for services rendered. I understand that I am responsible for all charges, even those not paid for by my insurance. I understand that by signing I am giving my permission for treatment. I also authorize **Premier Physical Therapy** to contact the insurance commissioner on my behalf, to assist me in receiving my full insurance benefits, if deemed necessary. I have read the above statement and fully understand my options. The option that I believe will handle my situation in the most optimal way would be Option # _____

X _____ X _____

Patient/ Guardian Signature Date

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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 well being and gain of your physical abilities is something we at Premier Physical Therapy take very seriously.

Because we care so much about you, we realize that 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 will write down your appointment times and dates for you so you do not forget. We will also complete reminder calls the day before your scheduled appointment.

With the exception of SERIOUS emergencies, it is expected that you keep all your appointments. If you need to reschedule an appointment, we require a 24 hour notice. In such a 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, preferable the very next day.

In an instance of a cancellation without 24 hours notice, or a no-show to a scheduled appointment, we reserve the right to charge you a $25.00 fee.

Should you cancel or no-show for 3 appointments without proper notice or reasons considered not appropriate, you may be discharged from the therapy program.

We appreciate you greatly as our patient and strive to accomplish wonderful results and success for you!

Dennis Riney, PT
Premier Physical Therapy

I have read and understand the above policy

Print Name_____

Signature _____ Date _____

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Credit Card on File Authorization Form

I agree to have my credit/debit card information on file with Premier Physical Therapy. This will only be used if I fail to pay my statement within 90 days from the first statement date.

Patient Credit Card Number: _____

Expiration Date: _____

CVC Number: _____

Print Patient Name: _____

Patient Signature: _____

Realease of Medical Information (HIPPA)

Please list anyone that you authorize to share your physical therapy information with. This medical information may be used by the person you authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as you may direct.

1. _____
2. _____
3. _____
4. _____
5. _____

I understand that I have the right to revoke this authorization, in writing, at any time. Please sign below authorizing the above individuals to have access to your physical therapy medical and billing information.

Print Patient Name: _____

Patient Signature: _____ Date: _____