Date____________________

First Name____________________________ Last Name____

Address____

City___________________________________ State___________________________ Zip________________

Date of Birth_______________________

Home number_______________________________ Work number___________________________________

Cell number_______________________________ Email ____

We bill electronically through your email and send text reminders through your cell phone

Occupation____

Employer____

Employer Address____________________________ City______________________ State_______ Zip__________

Emergency Contact________________________________ Phone Number_____________________________

*If patient is a minor please complete below

Parent's Cell Number________________________________ Parents Email ______________________________

If your appointment is a post-operative visit, what was the date of your surgery? _____________________________

Parents, please feel free to stay with your child/children during their PT sessions so that you can see and better understand the treatments that your child/children are undergoing.

Insurance Information

Insurance Carrier_________________ Policy #______________ Group#________________

Policy Holder__________________ Relationship-Self_____ Parent_____Spouse/Partner____

Policy Holder's Date of Birth__________________ (if other than self)

It is the patient's or guardian's responsibility to inform Philip Physical Therapy of any changes to your insurance coverage or carrier.

Physician's Information

Physician's Name & Address ____

____

Referring Physician's Name & Address____

____

Referral Information

Who can we thank for referring you to Philip Physical Therapy?

Friend, their name please:_________________________ Patch:______ New Canaanite:______

MD, their name please:___________________________ Website:_____ Internet Search:_____

Facebook:__________ St. Aloysius:___________

Summary of Notice of Privacy Practices

1. Uses and Disclosures of Your Health Information. We may use the information we develop and collect for treatment by our practice or disclose the information to others to whom we refer you for treatment, for payment for these services, and for certain healthcare operations such as improving the competence and quality of our staff and business planning and management. We may disclose your information to our billing associates and members of the treatment staff and those involved with the operation of our practice. We may call you to remind you of appointments and leave a message on your answering machine should you have one. Your medical information may be disclosed without your authorization as required by law, for public health purposes, healthcare oversight, including third party administrators, audits and investigations, judicial and administrative proceedings, subject to the limit imposed by state and federal law.
2. Other Uses and Disclosures. Except as described above, we will not use or disclose your medical information without your written authorization at any time, except to the extent that we have already taken action in reliance on the authorization.
3. Your Health Information Rights. You have a number of rights under state and/or federal law which are subject to the terms and conditions specified above.
   a. You may request restrictions on certain uses and disclosure of your information.
   b. You may request that you receive your information from us in a certain way.
   c. You may inspect and copy all of your medical records.
   d. You may request an amendment to any record you believe inaccurate.
   e. You may request an accounting of disclosure made of your record

4. Changes to the Notice. We reserve the right to change the aforementioned policies. If we do so, all changes will be posted in our office and a copy will be provided upon request.

Acknowledgement of Receipt of Notice of Privacy Practices

Name of patient____

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

Signed____ Date____________________________

If not signed by the patient, what is your relation to the patient?____

Informed Consent to Physical Therapy

I, ____ understand that I am to undergo a physical therapy evaluation and treatment for the following condition(s):

____

I acknowledge that the evaluation will include active and passive motions that are joint specific and remote in nature. I understand that the evaluation physical therapist will take all the necessary precautions to ensure modesty and comfort during the course of the evaluation and subsequent treatments. I accept the responsibility to inform my physical therapist of what I am experiencing so as to attain and maintain a clear and concise communication.

Please initial

__________ This office is subject to 24 hour audio and video surveillance

__________ I further understand that the evaluation and subsequent treatment(s) will likely include an assortment of the following activities:

- ✓ Passive/active range of motion
- ✓ Strengthening/stretching exercises
- ✓ Manual techniques (mobilization, myofascial release techniques, massage)
- ✓ Education
- ✓ Modalities (ice, heat, electrical stimulation, iontophoresis)

Signed ____ Date __________________________________

Terms of Service

1. Co-pay and/or other payment due at time of service.
2. There will be a $35 fee for returned checks.
3. If account remains unpaid and it is necessary to engage in collection actions all costs will be charges to the guarantor.
4. **24 hour notice of cancellation is to be provided otherwise $50 fee will be charged to your account.**

*It is the patient's or guardian's responsibility to inform Philip Physical Therapy of any changes to your insurance coverage or carrier.

Assignment and Release: I, the undersigned, assign directly to Philip Physical Therapy, all medical benefits payable to Philip Physical Therapy for services rendered. I hereby authorize Philip Physical Therapy to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that I am responsible to know my insurance benefits and that all charges not covered by my insurance company will be billed directly to me, as per my contract. Should my injury be related to a workplace or motor vehicle accident I will accept responsibility for physical therapy evaluation and treatment costs, should the claim be denied by the third party payer.

Signed ____ Date____

If not signed by the patient, what is your relation to the patient? ____

Medical History:

Name: ____ Next appointment with referring MD: ____________________
Injury:________________________________ Date of Injury: ___/___/______ Work or Vehicle related? Y / N
Have you had physical therapy in the last year? Y / N Date of last visit: ___/___/______

Please Circle those that apply to you:

AIDS/HIV	Breathing problems	Hepatitis	Open wound	
Anemia	Cancer	Herpes	Osteoporosis	Other:
Chest pain	Depression	High Blood Pressure	Pacemaker	A.____________________________
Aortic Aneurysm	Diabetes	Infection	Polio	B.____________________________
Arthritis	Dizziness/fainting	Joint replacement	Seizures	C.____________________________
Asthma	Emphysema	Kidney problems	Stroke	
Blood Disorders	Fibromyalgia	Lyme disease	Swelling of hands/feet	
Bowel/Bladder trouble	Heart Disease	Myofascial pain		

Medications:

1.___________________________ 2.___________________________ 3.___________________________ 4.___________________________
5.___________________________ 6.___________________________ 7.___________________________ 8.___________________________

Personal Information:

Height:_____________, Weight:___________,
Weight loss/gain in the last year? (Circle) + / - ________ pounds Are you pregnant? Yes No
Tobacco: Yes No Alcohol: (circle) Daily Weekly Monthly Yearly Not at all
Allergies: (circle) Bees Cortisone Latex Lotions Nuts Rubber Seasonal Strawberries Shellfish
Allergies: (other): ____

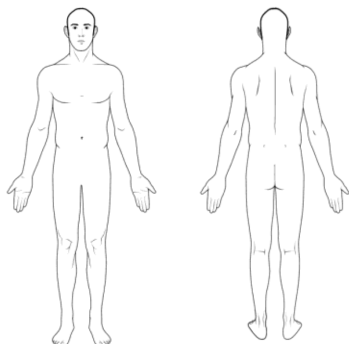
History of serious injury:

List all surgeries, serious injuries (fractures, dislocations, strains):

Injury:	Date:	
1.		Personal circumstances that may affect your physical therapy
2.		
3.		
4.		
5.		

Current injury:
Current injury onset: _____ Sudden _____ Gradually _____Traumatically
Current injury progression: _____ Improving _____Worsening _____ Neither

Mark on your body where you feel the described sensations. Include all affected areas even if they don't relate to this visit.



Does your condition Interfere with: (check)

_____ Bathing _____ House/ Yard work
_____ Vocation _____Walking _____ Sport/exercise
_____ Child care _____Sleeping _____Being Social
_____ Standing _____ Sitting
_____ Other: _______________________________

Rate the following: 0 is none/ absent, 10 is high/max
Min Pain level: 0 1 2 3 4 5 6 7 8 9 10
Max Pain level: 0 1 2 3 4 5 6 7 8 9 10

Rate the following: 0 is poor, 10 is good
Balance: 0 1 2 3 4 5 6 7 8 9 10
Have you fallen in the past year? Yes No
Do you use a brace? Yes No

Complete this page only if you would like to keep a credit card on file for yourself and your family

Credit Card on File Authorization

Many of our patients elect to keep a credit card on file to be charged after each visit. If you would like to utilize this convenience, please fill out the following information. If you do not choose to keep a credit card on file, we require payment in the form of check or credit card at the time of your visit.

__________ I understand that I am financially responsible for a patient this is a minor and that I am required to keep a credit card/ check card on file to be charged for all co-pays, co-insurance, and deductibles.

I ______________________________________ authorize Philip Physical Therapy to keep my credit card on file and charge my credit card as follows:

__________ For copayment/ co-insurance or my deductible at each visit. We will bill your insurance company so you will receive credit toward your deductible.

__________ I would like to keep my card on file for members of my immediate family.

_______ My credit card on file will be charged a $50.00 fee for same-day cancellations and no-shows.

Please complete the information below:

Cardholder name:____

Billing address:____

____

Account Number:____

Expiration date: _________________________

Receipt will be sent to your email address on file.

Signature:____

Date:________________________

I authorize the above named business to charge the credit card indicated in this authorization to the terms outlined above. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the business in writing of any changes to the account information or termination of this authorization. The payment authorization is for the type of bill indicated above. I certify that I am and authorized user of this credit card and I will not dispute the scheduled payment with my credit card company provided the transactions correspond to the terms indicated in this authorization form.