Select PHYSICAL THERAPY
The Power of Physical Therapy

Patient Information Form

Patient Demographic Information			
***Last Name**	***First Name**		***Middle Initial**
Address	City	State	Zip Code
***Home Phone**	***Appointment Reminder Contact Method** ☐Text ☐Mobile ☐Email ☐Home Phone (Choose method of choice) ☐No Appointment Reminder		
***Mobile Phone**	***Email Address** ☐Declined Email ☐No Email		
***Date of Birth**	SSN	***Sex** ☐F ☐M	Status ☐Single ☐Married ☐Other

Employer Information			
Employer	Employment Status ☐FT ☐PT ☐None ☐Retired ☐Student		
Address	City	State	Zip Code
Work Phone	Occupation		

Emergency Contact Information		
Contact Name	Phone	Relationship

Physician Information		
Referring Physician	Phone	Script Date

Additional Questions			
Injury /Onset Date	Post-Surgical ☐Yes ☐No	Surgery Date	Body Part/DX
Work Related ☐Yes ☐No	Accident Related ☐Yes ☐No	Auto Related ☐Yes ☐No	Attorney Involved ☐Yes ☐No
Adjuster/Nurse Cases Mgr.	Phone	Attorney	Phone
Have you had prior Therapy thisyear? (PT/OT/SP/Chiro) ☐Yes ☐No		How did you hear about us?	

Medicare ONLY! Additional Questions	
If Medicare, are you currently Receiving HomeHealth Services? ☐Yes ☐No	
If YES, Name of Agency	If discharged what is last date of service?
Are you currently residing in a Skilled Nursing Facility? If Yes, Name of facility	

Primary Insurance Section		Secondary Insurance Section	
***Insurance/Plan**		***Insurance/Plan**	
***Policy ID #**		***Policy ID #**	
***Group #**		***Group #**	
***Insurance Phone**		***Insurance Phone**	
Are you the policy holder? ☐Yes ☐No If no, continue		Are you the policy holder? ☐Yes ☐No If no, continue	
Card Holder Name	DOB	Card Holder Name	DOB
Patient Relationship to Policy holder ☐Self ☐Spouse ☐Child		Patient Relationship to Policy holder ☐Self ☐Spouse ☐Child	
Patient, Please initial here if the above information is correct and complete		Date	

Office Staff use ONLY (below)		
Intake Completed by	Date	***Date Eval Scheduled**
Registered by	Date	Acct #
Patient Service Specialist will initial next to each task below once completed.		
Billing Disclosure added in RT Comments☐	Verified DL/Photo ID☐	Consent to receive calls and/or text messages, reviewed with patient. If patient agrees and signed consent, is text enabled box checked in RT?☐

Last updated 8/24/18

Medical History Form

Patient Name: _____ Account Number: _____

Height: _____ft _____in Weight:_____(pounds) Date of injury:_____

Diagnosis as stated to you by your physician: _____

How did this injury/ exacerbation occur? _____

Have you been hospitalized for the present condition? □ Yes □ No If Yes, date: _____

Have you had surgery for the present condition? □ Yes □ No If Yes, date: _____

If yes, surgery type:_____

Have you had any falls this past year? □Yes □No If Yes, how many?_____

Have you received previous treatment for this condition? □ Yes □ No If Yes, date: _____

If yes, please summarize:_____

Have you ever had any of the following? □ EMG □ CT SCAN □ MYELOGRAM □ MRI □ XRAY

Have you ever, or are you presently being treated for any of the following conditions?

Acquired Respiratory Distress Syndrome	□ Yes	□No
Angina	□ Yes	□No
Anxiety or Panic Disorders	□ Yes	□No
Arthritis (RA, OA)	□ Yes	□No
Asthma	□ Yes	□No
Chronic Obstructive Pulmonary Disease (COPD)	□ Yes	□No
Congestive Heart Failure (CHF)	□ Yes	□No
Degenerative Disc Disease (back disease, spinal stenosis, severe chronic back pain)	□ Yes	□No
Depression	□ Yes	□No
Diabetes	□ Yes	□No
Emphysema	□ Yes	□No
Hearing Impairment	□ Yes	□No
Heart Attack	□ Yes	□No
Multiple Sclerosis	□ Yes	□No
Osteoporosis	□ Yes	□No
Parkinson's Disease	□ Yes	□No
Peripheral Vascular disease	□ Yes	□No
Stroke or TIA	□ Yes	□No
Upper Gastrointestinal Disease (ulcer, hernia, reflux)	□ Yes	□No
Visual Impairment (cataracts, glaucoma, macular degeneration)	□ Yes	□No

Allergies	□ Yes	□No
Headaches	□ Yes	□No
Back Injury	□ Yes	□No
Bleeding Disorders	□ Yes	□No
Bowel / Bladder Abnormalities	□ Yes	□No
Cancer	□ Yes	□No
Dizzy or Fainting Spells	□ Yes	□No
Epilepsy or Seizure Disorder	□ Yes	□No
Fracture	□ Yes	□No
Hepatitis A, B, C	□ Yes	□No
Hernia	□ Yes	□No
High Blood Pressure	□ Yes	□No
HIV/AIDS	□ Yes	□No
Hypoglycemia	□ Yes	□No
Immunosuppressant Condition or Medication	□ Yes	□No
Kidney Problems	□ Yes	□No
Liver / Gallbladder Problems	□ Yes	□No
Metal Implants	□ Yes	□No
Nausea / Vomiting	□ Yes	□No
Pacemaker	□ Yes	□No
Defibrillator	□ Yes	□No
Pregnancy	□ Yes	□No
Ringing in Your Ears	□ Yes	□No
Sexual Dysfunction	□ Yes	□No
Skin Abnormalities	□ Yes	□No
Smoking	□ Yes	□No
Special Diet Guidelines	□ Yes	□No
Tuberculosis	□ Yes	□No

Please continue to 2nd page

Patient Name: _____ Account Number: _____

Are you on any medications? Click here if attached: □ Attached Please list (you may use reverse side):

_____

_____

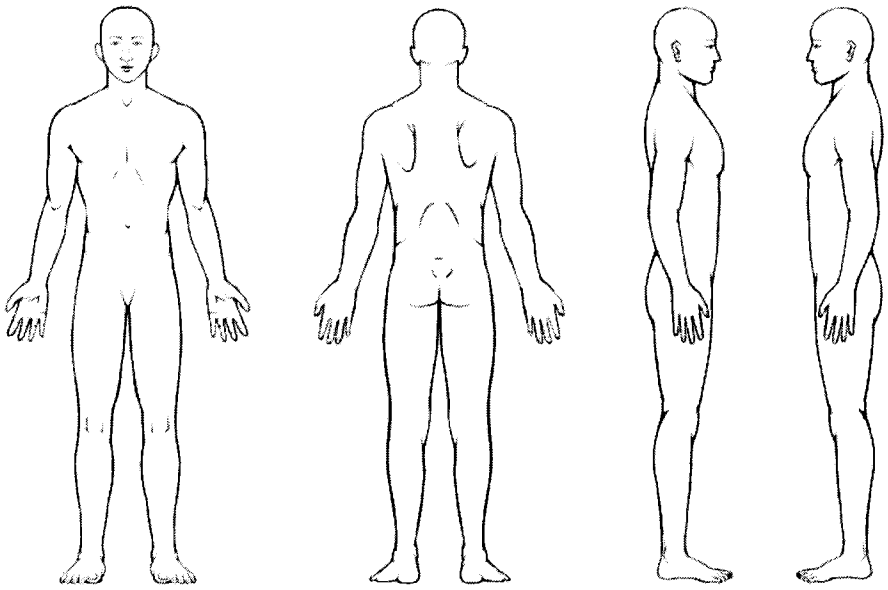
To help us understand your symptoms, please circle all that apply.

My pain is worse: in the morning/ during the day/ at night/ constant/ with activity/ during rest

On a scale of 0 to 10 (0 being no pain and 10 being unbearable pain requiring hospitalization)
Please rate your pain at its best _____ and at its worst_____

Pain Diagram

Using the key provided, please draw the symbol representing your pain over the area of the body as it relates to your present condition



Key

↑ or ↓ Radiating Pain
XXX Spasm
ZZZ Tenderness
//// Numbness/Tingling
000 Ache/Pain

Is there any other information regarding your medical history that we should know about? _____

_____

What is your goal for therapy at this time? _____

_____

Signature of Patient or Guardian (if patient is a minor): _____ Date: _____

Select PHYSICAL THERAPY
The Power of Physical Therapy

Consent to Treatment: Authorization to Release Information: and Statement of Financial Responsibility

Revised 08/01/2018

Patient Name:_____ **Date:**_____ **Acct#:**_____

Select Physical Therapy appreciates the confidence you have shown in choosing us to provide for your rehabilitative needs. The service you have elected to participate in implies a financial responsibility on your part. This responsibility obligates you to ensure payment in full of your fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for the payment of your bill.

You are responsible for payment of any co-payment at the time of service and for any deductible /coinsurance as determined by your contract with your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amount not covered by your insurer. If your insurance carrier denies any part of your claim, or if you and your physician elect to continue therapy past your approved period, you will be responsible for your account balance in full. If your account is not paid in full and is referred to a collection agency, any fees incurred in collecting on your unpaid balance will be your responsibility. For your convenience, we accept cash, checks and most major credit cards. Payment is expected by payment due date on your Monthly Patient Statement. Payments can be made at the center, mailed to the address on your statement, or you may access our on-line bill payment option @ www.selectphysicaltherapy.com/paybill once a statement is received from the billing office, or by calling our customer service department at 1-800-721-8202.

I have read the above policy regarding my financial responsibility to Select Physical Therapy for providing rehabilitative services to the above named patient or me. I certify that the information provided is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Select Physical Therapy. I agree to pay Select Physical Therapy the full and entire amount of all bills incurred by me or the above named patient, if applicable, any amount due after payment has been made by my insurance carrier. *Patient Service Specialist Initials:* _____

Signature: _____(relationship to patient: self – guardian – other:_____) **Date:**_____

You agree that in order for us to collect any amounts you may owe, we may contact you by any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and use of automatic dialing devices, as applicable.

Signature: _____(relationship to patient: self – guardian – other:_____) **Date:**_____

You will receive calls and/or text messages that deliver autodialed or pre-recorded telemarketing messages from an automatic telephone dialing system. You consent to receive such calls and/or texts at the telephone number associated with your account. Your consent to receive such calls and/or text messages is not a condition of any purchase of a service or product.
I/We have read this disclosure and agree that Provider, and/or their representative, may contact me/us as described above.

Signature: _____(relationship to patient: self – guardian – other:_____) **Date:**_____

I acknowledge that the Notice of Privacy Practices and Notice for Federal Civil Rights is posted at the location in which I am receiving treatment and that I have read and understand the notice. I further acknowledge that I have the right to request a copy of the notice and one will be provided to me.

Signature: _____(relationship to patient: self - guardian - other: _____) **Date:**_____

CONSENT OF TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION

I am aware of my diagnosis and voluntarily consent to have Select Physical Therapy, through its appropriate personnel, provide evaluation and/or treatment as prescribed by my physician and/or recommended by my therapist. I understand the practice of physical, speech, and occupational therapy is not an exact science, and I acknowledge that no guarantees have been given to me regarding the successful completion or the results of the treatment provided. I understand that the treatment I receive from Select Physical Therapy is limited to physical, speech, and/or occupational therapy services and that I shall seek treatment from other medical professionals for all other issues I may experience. I understand that I have the right to ask questions at any time during the course of my care.

Signature: _____(relationship to patient: self - guardian - other: _____) **Date:** _____

I further authorize Select Physical Therapy to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment necessary to secure payment for services provided.

Signature: _____(relationship to patient: self - guardian - other: _____) **Date:**_____

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PATIENT NAME:_____ **DATE:**_____ **ACCT#:**_____

NOTIFICATION of PATIENT RESPONSIBILITY for CO-PAYMENTS / CO-INSURANCE % and DEDUCTIBLES

Your insurance company requires Select Physical Therapy to collect your co-payment amount from you at the time of service. If we do not collect these amounts we could be in violation of our contract with your insurance company and risk being denied reimbursement for your treatment. Furthermore, we have an obligation to collect any co-insurance % or unmet deductible amounts from you that are determined to be your responsibility.

You will receive statements from us during and after your treatment for any outstanding amounts your insurance company indicates will be your financial responsibility. These statements will also include the amount billed to your insurance company and the payments received from both you and your insurance company.

BILLING DISCLOSURES TO INDIVIDUALS INVOLVED IN PATIENT'S CARE

There may be times when it is necessary for an individual directly involved in your care to call the facility to inquire about your personal health information or billing information. Please take a few moments to complete this section.

I authorize Select Physical Therapy to disclose my health information that is directly related to my current treatment at Select Physical Therapy to the individual(s) listed below for purposes of their role in my treatment or payment or payment for the health services that I have received.

Such persons involved in your care may include: spouse, children, blood relatives, roommates, boyfriends/girlfriends, domestic partners, neighbors and colleagues.

NAME	RELATIONSHIP

I do not wish to have my health information disclosed to individuals involved in my care.

NAME	RELATIONSHIP

Select Physical Therapy has verified Outpatient Physical Therapy/Occupational Therapy/Speech Therapy benefits based on the information furnished to us by you. Your Insurance Company has the disclaimer that this is verification of benefits and not a guarantee of payment. Based on the information your insurance company provided to us, the estimated amount you are responsible for is:

Co-Payment_____/Visit

Co-Insurance_____% of allowed amount

Deductible Amount_____ Amount Not Met _____

Maximum Visits/Days_____ Per Person / Condition / Year / Lifetime

Maximum Dollar Amount_____ Out of Pocket Maximum _____

Other Benefit Information _____

NOTE: ***ESTIMATED coverage information is provided as a courtesy to our patients, but is not intended to release them from total responsibility of their account balance. The estimation is based on a negotiated contract and any remaining balance due will be billed to you after additional information is received from your insurance company.***

We are committed to Service Excellence to our patients. If you have questions or concerns about your billing, please contact our Centralized Business Office at (800)721-8202. Thank you.