**PATIENT INFORMATION**

**Date\_\_\_\_\_\_\_\_\_\_**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Apt. #\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_

Primary Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Secondary Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth\_\_\_\_\_\_\_\_\_\_\_Social Security#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male Female

Email Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: Married Single Former Patient: Yes No

What is your primary language?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please tell us how you heard of FIT Physical Therapy by circling:

Website Physician Referral Family/Friend Insurance Company Location/Signage Flyer Club/Organization Advertisement Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMPLOYMENT INFORMATION**

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PHYSICIAN INFORMATION**

Referring Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACT**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_

Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_

**ADDITIONAL INFORMATION**

Is this an approved Worker’s Comp Injury? Yes No Date of Injury\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this an Auto Accident? Yes No

Is this a Lawsuit? Yes No

Attorney Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_ Fax\_\_\_\_\_\_\_\_\_\_\_\_

**WORKERS COMPENSATION**

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_Zip\_\_\_\_\_\_

Claim Adjustor Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Claim#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Claims Adjustor Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rehab Nurse Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax\_\_\_\_\_\_\_\_\_\_

Nurse Case Management Co. Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_Fax\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION**

Primary Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Policy Holder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_

Secondary Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Policy Holder\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_

**We strongly recommend that you verify your benefits with your insurance company.**

**SCREENING FORM**

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age\_\_\_\_\_Height\_\_\_\_\_\_Weight\_\_\_\_\_\_\_\_\_

What are you being treated for today?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What date (approximately) did your symptoms start?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My symptoms are currently GETTING BETTER GETTING WORSE STAYING THE SAME

Treatment received so far for this problem Chiropractic Acupuncture Injections

Physical/Occupational Therapy Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you received physical/occupational therapy within the last calendar year? Yes No

If yes, approximately how many treatment sessions have you received?\_\_\_\_\_\_\_\_\_

Special tests performed for this problem and results: X-Ray Bone Scan CT Scan MRI Other\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation, including activities that comprise your workday Sitting Standing Walking Lifting

Driving Repetitive Motion Typing Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you on a work restriction from your doctor? Light Duty Full Duty Not Working

Leisure Activities: Include exercise routines\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies – List any medication you are allergic to\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list significant past medical history and any surgeries (please indicate if it was for the current condition)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Known Health Problems (please circle):

|  |  |  |  |
| --- | --- | --- | --- |
| Alcohol/Drug abuse | Allergies | Asthma | Cancer |
|  |  |  |  |
| Depression | Diabetes | High Blood Pressure | High Cholesterol |
|  |  |  |  |
| Mental Illness | Stroke | Other | Other |

During the past month, have you been bothered by feeling down, depressed or hopeless? YES NO

During the past month, have you been bothered by having little interest or pleasure in doing things? YES No

Is this something with which you would like help? YES YES, BUT NOT TODAY NO

Is there anything else we should know that is pertinent to your treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your goal for therapy?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all of the prescription medications you are currently taking

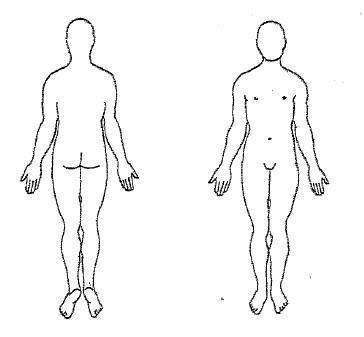
|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Medication** | **Dosage**  (how many or how much you take) | **Frequency**  (how often you take it) | **ROUTE**  (how you take it - by mouth, injection, etc) |
|  |  |  |  |
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|  |  |  |  |

List all over-the-counter Medications you are currently taking

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Medication** | **Dosage**  (how many or how much you take) | **Frequency**  (how often you take it) | **ROUTE**  (how you take it - by mouth, injection, etc) |
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List all herbals, vitamins, minerals, nutritional supplements you are currently taking

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Medication** | **Dosage**  (how many or how much you take) | **Frequency**  (how often you take it) | **ROUTE**  (how you take it - by mouth, injection, etc) |
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Please mark the areas where you feel symptoms, using the following symbols to describe your symptoms:

|  |  |
| --- | --- |
| Checkmark | Shooting/Sharp Pain |
|  | Dull/Aching Pain |
| Add | Numbness |
| Close | Tingling |

My symptoms currently:

|  |  |  |
| --- | --- | --- |
| COME AND GO | ARE CONSTANT | CONSTANT, BUT CHANGE WITH ACTIVITY |

What makes your symptoms *better?*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes your symptoms *worse?*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

FIT Physical Therapy is dedicated to maintaining the privacy of your health information and complying with federal laws that help protect it. The following information is a summary of our privacy practices and how we may use and disclose your health information. The full-length version follows this summary as a laminated copy. It also describes your rights regarding how you may gain access to and control your health information. We encourage you to read the Notice of Privacy Practices in its entirety. If you would like a hard copy, please notify the front desk.

* We will use and disclose your health information in the course of providing, coordinating, or managing your medical treatment.
* We will use and disclose your health information to obtain payment for health care services provided to you.
* We may use your health information in performing a variety of health care operations that allow us to improve the quality of care that we provide you.
* We may contact you and/or leave a voicemail message to remind you of your scheduled appointment.

Signature of Patient/Representative\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_

Name of Patient or Representative\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to patient\_\_\_\_\_\_\_\_\_

**CANCELLATION POLICY ACKNOWLEDGEMENT**

* Please give us a 24-hour notice when cancelling or rescheduling appointments. Office appointments canceled with less than 24-hour notification and No-Shows will be subject to a $45.00 fee.
* If you arrive more than 15 minutes late for your scheduled appointment, you may be rescheduled.
* We recommend that you schedule at least a week in advance in order to get the time slots that you need.
* If you do not show up for three consecutive appointments, you will be discharged from physical therapy.
* In order to help you reach you goals for physical therapy, it is extremely important for you to regularly attend your physical therapy sessions and perform your home exercise program as prescribed by your physical therapist.

Signature of Patient/Representative\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_

Therapist Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_

**TREATMENT AUTHORIZATION**

Your signature is required below to authorize treatment. Your signature also authorizes the release of medical information needed to process your claim, allowing an assignment of benefits where a claim has been filed, and acknowledging your understanding of the above office policies. An additional treatment authorization signature is required by a parent/legal guardian of all minors.

Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_

Print Full Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_

Print Full Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HIPAA AUTHORIZATION**

In compliance with HIPAA regulations, I authorize the following individuals to receive verbal information regarding the billing of my account.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name/Relationship Name/Relationship Name/Relationship**

**ADDITIONAL SERVICES**

We offer reduced rates for Yoga, Pilates and Massage to all our clients.

These services are not considered Physical Therapy, and they are not covered by insurance.

If you choose to participate, you understand that we will not bill your insurance company and you will be responsible for the entire cost.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_

**FINANCIAL POLICY / NOTIFICATION OF PATIENT RESPONSIBILITY**

**FIT Physical Therapy will bill your insurance carrier solely as a courtesy to you.**

**It is our policy to collect your copayments, coinsurances and/or any unmet deductible amounts from you at the time of service.**

**Please be advised that unless told otherwise, we will use the credit card that you provided at either the time you made the appointment or at your first visit.**

We have verified your Physical Therapy benefits with your insurance company, based on the information provided by you. Please be advised that your insurance company has the disclaimer that this is a verification of benefits only, and not a guarantee of payment. Benefits/payments are determined once the claim is received. We do not accept responsibility for the accuracy of the information provided by your insurance company. We recommend that you contact your insurance company directly if you have any further questions or concerns regarding your benefits.

**PLEASE NOTE:**  You are ultimately responsible for all payment obligations arising out of your treatment or care and guarantee payment for these services. You are responsible for deductibles, co-payments, coinsurance amounts or any other patient responsibility indicated by your insurance carrier.

**IF YOU ARE A CASH-PAYMENT PATIENT**, you are responsible for all payment obligations arising out of your treatment and care and guarantee payment for these services.

Please verify that you understand your financial responsibility by signing and dating this form:

Patient/Guardian/Responsible Party:

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_

**FITNESS WAIVER AND RELEASE**

I understand that fitness programs include physical movements as well as an opportunity for relaxation, stress re-education and relief of muscular tension in either a group setting or independently. As is the case with any physical activity, the risk of injury, even serious or disabling, is always present and cannot be entirely eliminated. If I experience any pain or discomfort, I will listen to my body, discontinue the activity and ask for support from the instructor or nearby employee. I assume full responsibility for any and all damages, which may incur through participation.

Fitness programs are not a substitute for medical attention, examination, diagnosis or treatment. Fitness programs are not recommended and are not safe under certain medical conditions. By signing, I affirm that a licensed physician has verified my good health and physical condition to participate in such a fitness program. In addition, I will make the instructor aware of any medical conditions or physical limitations before class to seek modifications. If I am pregnant, become pregnant or I am post-natal or post-surgical, or have any changes to my cardiac, pulmonary or neurologic status, my signature verifies that I have sought my physician’s approval to participate. I also affirm that I alone am responsible to decide whether to participate in a fitness program and participation is at my own risk. I hereby agree to irrevocably release and waive any claims that I have now or may have hereafter against FIT Physical Therapy, LLC and the facility.

My signature verifies that I agree to only use equipment and exercises which I have been instructed in their use. I have read and fully understand and agree to the above terms of this Liability Waiver Agreement, I am signing this agreement voluntarily and recognize that my signature serves as complete and unconditional release of all liability to the greatest extent allowed by law in the State of Texas.

I further understand that Fitness programs are not considered Physical Therapy.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_