Patient Information

Patient Name:_____ Date of Birth:_____
(Last) (First) (MI)
Preferred Name:_____

Mailing Address:_____
(number and street) (city) (state) (zip code)

Phone #:_____ Alternate Phone #:_____

Employer:_____ Social Security #:_____

Email:_____ Marital Status (circle): Married Single Widowed

Emergency Contact Name:_____ Phone #:_____

Referring Physician:_____ Date of Injury:_____

Primary Care Physician:_____

We provide courtesy appointment reminders. Do you prefer:

- ☐ Email
- ☐ Phone
- ☐ Text

Who can we thank for referring you to our clinic? _____

Insurance Information

Primary Insurance Name and Address:_____
_____

Subscribers Name:_____ Group #:_____ ID #:_____

Secondary Insurance Name and Address:_____
_____

Subscribers Name:_____ Group #:_____ ID #:_____

Workers Compensation Carrier:_____ Claim #:_____

Consent to Treat

I, the undersigned, do hereby agree and give my consent for Hometown Physical Therapy to

furnish medical care and treatment to_____ as considered necessary
(Patient's Name)
and proper in diagnosing or treating his/her physical condition.

Release of Information/Benefit Assignment

I, undersigned, do hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third party payers to Hometown Physical Therapy. A photocopy of the assignment is to be considered as valid as the original. I, the undersigned, do hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment.

_____	_____	_____
Patient/Guardian Signature	Patient/Guardian Print Name	Date

Notice of Privacy Practices

I understand that Hometown Physical Therapy complies with HIPAA and will protect my Protected Health Information (PHI) and will use it as allowable by law in the treatment, billing and collection pertaining to my care until my case is closed and full payment is received. I also authorize the release of any information pertinent to my case to any insurance company, adjustor, or attorney for the purpose of securing payment under this policy of insurance or to any Medical Provider associated with my case to effectively treat me. A photocopy of the assignment is to be considered as valid as the original. Please see attached notice of Privacy Practices. Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

_____	_____
Signature of Patient/Guardian	Date

Financial Policy Statement

As a courtesy to me, Hometown Physical Therapy will file claims to my insurance company, but payment for treatment is my responsibility whether my insurance carrier pays. Estimated payment, deductible, and co-insurance or co-pays are MY responsibility and are due upon services rendered. If my insurance carrier does not send payment within 120 days, I am responsible for the balance. In the event that my insurance company requests a refund of payment made, I will be responsible for the amount of money refunded to my insurance company. If any payment is made directly to me for service billed by Hometown Physical Therapy, it is my obligation to promptly send payment to Hometown Physical Therapy. I understand it is my responsibility to contact my insurance carrier to verify my own benefits and to be aware of any contract limitations. I understand that co-pays and/or co-insurance payments are due at the time of treatment or visit. I also understand that my deductible amount must also be satisfied. I understand it is my responsibility to inform this office of any changes to my medical insurance status.

_____

(Signature of patient/guardian)

Please Initial:

_____ I understand that I am responsible for all charges incurred regardless of insurance or third party liability.

_____ I authorize contact by the use of my mobile/cell phone number for discussing treatment, confirming appointments and resolution of the balance of my account.

_____ I authorize Hometown Physical Therapy to release any medical information necessary to process my claim to my insurance company or to any other concerned third party.

_____ I understand that I will bear the cost for all associated collections and/or attorney/legal fees if my account is placed with a third party agency and/or attorney for collections or legal action.

_____ I authorize my insurance company or any other concerned third party to make payment directly to Hometown Physical Therapy.

_____ _____

(SIGNATURE) (DATE)

Patients with Cancelled or No-Show appointments,
with less than a 24-hour notification, will result in a $25.00 fee not billable to insurance,
which must be paid on or before the next appointment date

Patient Health History

Patient Name:_____ Date of Birth:_____

Type of Injury/Condition:_____

Date of Injury:_____ Surgery (Circle) Yes/No Date of Surgery_____

If Yes, Type of Surgery:_____

Next Doctor Appointment?_____

Describe Previous Treatments for this Condition: _____
_____
_____

Have you received Physical Therapy this year? Yes/No
Are you currently pregnant? Yes/No
Have you had any recent imaging done? Yes/No
If yes, please describe type and location_____
_____
_____

Have you recently noted:

- ☐ Weight Loss/Gain
- ☐ Weakness
- ☐ Pain w/ coughing or sneezing
- ☐ Pain at night
- ☐ Nausea
- ☐ Vomiting
- ☐ Fever/Chills/Sweats
- ☐ Cramps in legs when walking
- ☐ Fatigue
- ☐ Numbness/tingling
- ☐ Change in vision
- ☐ Insomnia

Do you have now, or have you had any of the following?

- ☐ Surgeries
- ☐ Sprains/Strains
- ☐ Heart Problems
- ☐ Circulation Problems/Clots
- ☐ Easy Bruising/Bleeding
- ☐ Allergies/Skin Sensitivities
- ☐ Loss of Consciousness
- ☐ Diabetes
- ☐ Cancer
- ☐ Asthma/Breathing Problems
- ☐ Leg/ Ankle Swelling
- ☐ Fainting
- ☐ Fractures
- ☐ High Blood Pressure
- ☐ Pacemaker
- ☐ Vehicle Accident
- ☐ Lung Disease
- ☐ UTI/Infections

Are you currently taking any medication? Yes/No

Name or type of Medication/what the medication is for:

_____

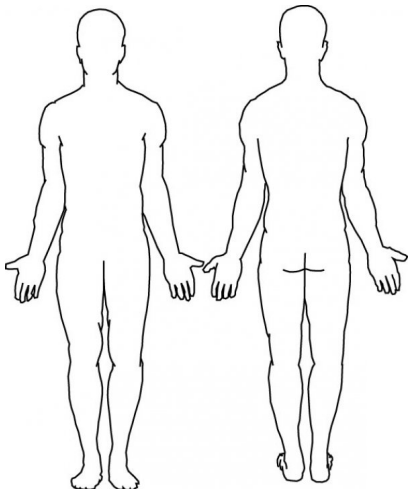
Please describe your type of pain (if applicable)

- ☐ Sharp
- ☐ Burning
- ☐ Aching
- ☐ Tingling
- ☐ Numbness
- ☐ Other:_____

Rate your pain 0 – 10 (0 minimum, 10 severe):

- On average:_____
- At worst:_____
- At best:_____

Circle area of pain:



What do you expect to accomplish, or be able to do better, with physical therapy?_____

_____

_____

_____