



New Patient Packet

To better serve you, it is important that you complete this medical history as completely and as accurately as possible.

PERSONAL INFORMATION

Name: _____ Date: _____

Mailing Address _____

City _____ St _____ Zip _____

Home Phone: _____ Mobile: _____ Email: _____

Date of Birth: _____ Age: _____ Sex: M F

Marital Status: Single Married Widowed Other _____

Social Security #: _____ Can we text you about your appt? Yes No

Primary Insurance: If same as above, check here _____

Insured's Name: _____ Date of Birth: _____

Phone: (____) _____ - _____ Employer: _____

Relationship to patient: Spouse Parent Other _____

Secondary Insurance: If same as above, check here _____

Insured's Name: _____ Date of Birth: _____

Phone: (____) _____ - _____ Employer: _____

Responsible Party Information (If under 18 years of age)

Name: _____ Phone Number: _____

Relationship to Patient: _____ Date of Birth: _____

Employer: _____ Employer Phone #: _____

CONSENT TO DISCLOSE PATIENT INFORMATION / HIPPA

"I understand this center's Notice of Privacy Practices and give permission for my protected health information to be disclosed for purposes of communicating results, findings, care decisions and appointments to the family members or friends listed below."

	Relationship	Phone #
Name _____		
Name _____		
Name _____		

Patient Name (please print) _____

Patient / Guardian Signature _____ Date _____

Other Information

Do you smoke? Yes No How Much? _____ Do you drink? Yes No How Much? _____

Do you exercise regularly? Yes No How Much? _____

PERSONAL INFORMATION

Please check YES if you have ever (in your life) had, or do you presently have any of the following

		YES			YES					YES
1	Anemia / Blood Disease		9	Diabetes		17	High Blood Pressure or High Cholesterol			
2	Bone / Joint Problem		10	Dizziness / Fainting		18	Lung Disease			
3	Arthritis / Rheumatism		11	Epilepsy / Seizure Disorder		19	Paralysis			
4	Allergies		12	Fibromyalgia Syndrome		20	Pregnancy (Current)			
5	Back Trouble		13	Headaches		21	Skin Disease or Sores That Won't Heal			
6	Breathing Problems (any kind)		14	Head / Spinal Injury		22	Stroke			
7	Broken Bones / Dislocation / Sprains		15	Heart Disease / Chest Pain		23	Swelling of Feet or Joints			
8	Cancer or Tumor		16	Hernia / Rupture		24	Mental Health			

Please give details of all above YES answers below (listing the corresponding number)

Number	Illness Details

Medical History

Medications

Are you allergic to any medications? YES / NO If YES, what? _____

If you are currently taking any medications please list below

Medication	
1	
2	
3	
4	

Medication	
5	
6	
7	
8	

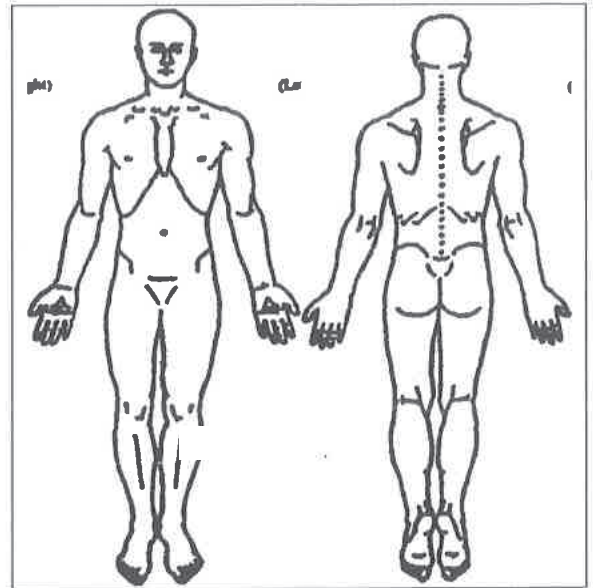
Pain Evaluation

PART IV PAIN LEVEL EVALUATION

Using the 0 to 10 scale below, please circle your pain level during the last week

Using the chart below and to the right, please indicate with an "X" the location of any pain, numbness or tingling you have experienced during the last week

No Pain	0	1	2	3	4	5	6	7	8	9	10	Severe Pain
<hr/>												



"I certify that I have reviewed and understand the above information supplied by me, and that it is true and correct to the best of my knowledge"

Patient Signature

Date

CURRENT WEIGHT:

CURRENT HEIGHT:



Charges and Payments

All Professional services are charged to the patient. Payment is due at the time services are rendered. We do file insurance for you as a courtesy; however **you are personally responsible for all charges incurred.**

To our Medicare Patients: We would like to remind you that our physicians are participating and do accept assignment. We ask that you pay at the time services are rendered only if your calendar year deductible has not yet been met or if you do not have a "supplementary" coverage. In this case, 20% of the charge would be payable.

Authorization and Assignment: I hereby authorize Therapy Plus Clinic, Inc to furnish information to my insurance carrier(s) and/or the referring MD, Dr. _____ concerning my illness and treatment thereof. I hereby assign Therapy Plus all insurance payments for medical services rendered to me or my dependents including Medicare. I understand that I will be responsible for all legal fees in the collection of my account should this become necessary.

Referring Physician: _____

Next Dr. Appointment: _____

Signature _____ Date _____



Patient Attendance Policy

In order to assure that all patients receive the time and attention they deserve, the following guidelines have been established.

1. If you arrive late for a scheduled appointment, you may not be able to be seen that day.
2. If you need to cancel an appointment, please notify us as soon as possible. If you are unable to make your scheduled appointment, please cancel 24 hours prior to appointment. (We have an answering machine you can leave a message on at all times.)
3. If you cancel with less than a 24 hours notice or miss your scheduled appointment ***more than twice***, you will be discharged. We will notify your referring physician of non-compliance.

Please note that any cancellation/no show fees are at the discretion of the treating therapist and/or the front desk manager. If you fail to keep scheduled appointments, you may be discharged from therapy.

"I have read and understand this policy"

Patient Name (please print) _____

Patient / Guardian Signature _____ Date _____



Your Rights and Responsibilities as a Patient

Therapy+Plus wants to inform you of your rights and responsibilities as a patient. Therapy+Plus supports your rights and responsibilities, and wants you to be an informed participant in your care. We regard each patient as an individual with unique personal, spiritual, social, mental and cultural needs.

Your Rights

- **You have the right to considerate, timely, respectful care as an individual person, by Competent personnel responsive to your needs and the urgency of your symptoms.**
- **We will treat you, refer you, or transfer you to another facility in order to best meet your needs. All referrals and transfers require your consent and the acceptance of the receiving institute.**
- **You have the right to access protective services and be free from all forms of abuse, neglect, or harassment.**
- **You have the right to the name of your therapist and all other staff who treat you or relate to you during your care.**
- **You have the right to accurate information from your therapist about the treatment plan and the expected course of treatment.**
- **You have a right to have an understandable explanation about any treatment or procedure so that you can make informed decisions about your care.**
- **You have the right to consent to or refuse treatment.**
- **You have a right to express concerns or disappointment with the quality of the care you receive.**
- **You have a right to obtain the information in your medical record.**
- **You have a right to privacy and confidentiality about your body, personal life, records, and your discussions with healthcare providers. Only persons involved in your care or treatment and payment for that care of treatment, will have access to you and your information; and only to the extent necessary.**
- **You have a right to a full explanation of your bill and may request an itemized statement. You may also ask questions about specific items on the bill. You have a right to counseling about financial resources for health care.**
- **You have a right to be free from discrimination of any kind.**

Continued on next page

Your Rights and Responsibilities as a Patient (continued)

Your Responsibilities

- You are responsible to provide an accurate explanation of the health issue that brought you to Therapy+Plus and to furnish your medical history.
- You are responsible to seek complete understanding of the treatment plan offered by Therapy+Plus. You are responsible to make decisions about accepting or refusing care.
- When you accept or refuse care, you are responsible to discuss the plan of care with your therapist. You must understand the risks, benefits, and alternatives of your decision to accept or refuse the plan of care.
- You are responsible to share concerns that you have. When you are not satisfied, you need to let the staff know what is not satisfying you.
- You are responsible to be a participant in your care by making sure that you understand instructions, that you ask questions when you don't understand, and that you report positive and negative responses to therapy.
- The Therapy+Plus staff and your physician need your active participation in the management of pain. Let us know about your pain or questions you have about your pain. We need to know if pain control measures are working for you. If your pain is not controlled, you need to tell us. You are an active partner in the management of your pain.
- You are responsible to meet or make arrangements for the financial obligations related to your healthcare.
- You are responsible to respect the rights and property of other patients, and of the personnel at Therapy+Plus. Out of concern for others, should there be someone accompanying you to your physical therapy appointment, you are responsible for the number of visitors, the conduct and noise control of these visitors.

I have read and understand my rights and responsibilities as outlined above. I am signing this form to indicate such and to acknowledge that my signature will be kept in my file at Therapy+Plus should questions arise in the future.

Name _____ Date _____