Patient Information

NAME_____ SSN_____

ADDRESS_____ CITY _____ STATE _____ ZIP _____

DATE OF BIRTH _____ GENDER: MALE FEMALE HEIGHT_____ WEIGHT_____

HOME PHONE ( ) _____ MOBILE ( ) _____WORK ( ) _____

EMERGENCY CONTACT _____ PHONE ( ) _____

RELATIONSHIP_____ PHONE ( ) _____

CAUSE OF COMPLAINT DUE TO: AUTO____ WORK ____ OTHER _____ DATE OF INJURY OR SURGERY _____

INSURANCE INFORMATION

PRIMARY

NAME OF INSURANCE COMPANY _____

POLICY HOLDER NAME _____ DATE OF BIRTH _____

ADDRESS (IF DIFFERENT THAN PATIENT) _____

RELATIONSHIP TO PATIENT _____ PHONE ( ) _____

SECONDARY

NAME OF INSURANCE COMPANY _____

POLICY HOLDER NAME _____ DATE OF BIRTH _____

ADDRESS (IF DIFFERENT THAN PATIENT) _____

RELATIONSHIP TO PATIENT _____ PHONE ( ) _____

WORKERS' COMPENSATION/AUTO INFORMATION

NAME OF INSURANCE COMPANY _____ PHONE ( ) _____

ADDRESS TO SUBMIT CLAIMS_____

ADJUSTER _____ PHONE ( ) _____ FAX ( ) _____

DATE OF INJURY _____ CLAIM # _____ PREVIOUS OT/PT (THIS INJURY) Y N

EMPLOYER _____

AUTO PATIENTS ONLY: POLICY HOLDER _____ RELATIONSHIP _____

AUTO POLICY #_____

REFERRING PHYSICIAN: _____ NEXT VISIT _____

PRIMARY CARE PHYSICIAN: _____ NEXT VISIT _____

HOW DID YOU HEAR ABOUT SUMMIT PHYSICAL THERAPY _____

WOULD YOU LIKE TO BE SIGNED UP FOR ***ELECTRONIC BILLING STATEMENTS?*** YES NO

(IF "YES") EMAIL ADDRESS:_____

SUMMIT
PHYSICAL THERAPY
& MASSAGE

Thank you for choosing us as your physical therapy provider. We are committed to providing you with quality and affordable health care. Please read our payment/consent policy, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments. All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. If payment is made in full at the time of the visit you will receive a 20% discount otherwise we can set you up on a monthly payment plan. Failure to comply with the payment plan will result in payment due in full.

4. Proof of insurance. All patients must complete our patient information form before seeing the therapist. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 10 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we will refer your account to a collection agency.

8. Consent to Treat. I consent to have this healthcare provider and/or its affiliates provide the treatment and care prescribed by my physician(s). I understand this consent may be evoked by me at any time

9. Missed appointments or late cancellations. Our policy is to charge $25.00 for missed appointments and appointments canceled less than 24hrs in advance. This charge will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment/consent policy. Please let us know if you have any questions or concerns.

I have read and understand the payment/consent policy and agree to abide by its guidelines:

_____

Print patient's full name

_____ _____

Signature of patient or responsible party **Date**

PATIENT MEDICAL HISTORY

Patient name _____

Were you referred by a physician? YES NO Doctor's name _____

Reason for referral _____

Briefly describe the onset and pattern of symptoms: _____

_____

Have you had any diagnostic tests (e.g., x-rays, CT scan, MRI, EMG, mylogram) done as a result of this condition?

YES NO If so, please circle which tests were done.

Have you had prior treatment for this same condition? YES NO

If so, please describe _____

Do you now or have you ever had any of the following:

	YES	NO		YES	NO
High blood Pressure	____	____	Bowel & bladder	____	____
Cardiac	____	____	Night Sweats	____	____
Cancer	____	____	Metal Implants	____	____
Diabetes	____	____	Pace Maker	____	____
Are you now pregnant	____	____	Lung	____	____
Arthritis	____	____	Allergies	____	____

Please list all allergies and the reaction they cause _____

_____

Please list previous surgeries/hospitalizations.

Brief description of Procedure	Date
_____	_____
_____	_____
_____	_____
_____	_____

If you need additional room, please use the back of this sheet.

Medications taking for current condition: _____

Medications taking for other conditions:

Medication	Condition
_____	_____
_____	_____
_____	_____
_____	_____

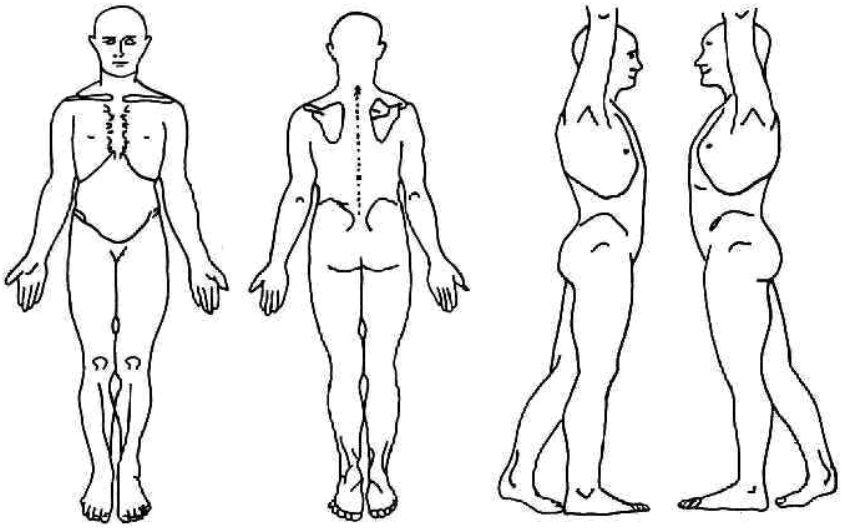
If you need additional room, please use the back of this sheet.

Over-the-counter medications currently taking: _____

PAIN DIAGRAM

Name_____Height_____Weight_____

Please mark the areas of your symptoms as they are at this moment of your evaluation.



Front
Right Left

Back
Left Right

Side
Right

Side
Left

Using the numbers diagram as a guide, rate the level of pain you have experienced: at its worst, best, and currently.

Worst _____ Best _____ Current _____

Problem List: List up to four things you ***cannot do now*** that you ***were able to do prior*** to the onset of symptoms:

1. _____ 3._____
2. _____ 4._____