

Woodstock Physical Therapy



Where Rehab is a Sport

How did you hear about Woodstock Physical Therapy? _____

Patient Information

Mr. Mrs. Ms. First _____ M.I. _____ Last _____ Date of Birth: _____ Age: _____

SS#: _____ Sex: M / F Marital Status: Single / Married / Divorced

Address: _____ City: _____ State: _____ Zip: _____

Billing Address if different: _____

Home: _____ Work: _____ Cell: _____ Occupation: _____

(If Minor) Mother's Name: _____ Father's Name: _____

Email address: _____

Employer Name: _____ Address: _____ Phone: _____

Emergency Contact: Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Insurance Information

Primary Insurance: _____

Secondary Insurance: _____

Policy Holder: _____

Policy Holder: _____

Member ID: _____

Member ID: _____

Relationship to Patient: _____

Relationship to Patient: _____

CONSENT TO TREAT

I do hereby consent to such treatment as prescribed by my physician/physical therapist or by any other physician/physical therapist who may be treating me. I understand that only care appropriate to the setting will be provided and that the above company will, at all times, exercise good faith in this relationship. This consent is intended as a waiver of liability for such treatment with exception of acts of negligence.

Signature of Patient, or Guardian

Date

Woodstock Physical Therapy Medical History

Name: _____

Date: _____

Physician Information

Referring Physician: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Type of Injury: _____ Date of Injury: _____

Please Describe How the Injury Occurred: _____

Have you had Physical Therapy this calendar year? Yes _____ How many visits? _____ No _____

Please Answer the Following Questions Regarding Your Pain/Symptoms:

My Pain is Worse in the: Morning / Evening / Same / Fluctuates / In Constant Pain

Please List Any Activities that Increase or Decrease Your Pain/Symptoms:

Is your pain: Dull Ache / Burning / Shooting / Sharp / Tingling

What is your level of pain right now?

NO PAIN _____ WORST PAIN EVER

1 2 3 4 5 6 7 8 9 10

If yes please explain: _____

Medical History

	YOU		IMMEDIATE FAMILY	
Cancer	YES	NO	YES	NO
Heart problems	YES	NO	YES	NO
High blood pressure	YES	NO	YES	NO
Asthma	YES	NO	YES	NO
Emphysema	YES	NO	YES	NO
Chemical dependency	YES	NO	YES	NO
Thyroid problems	YES	NO	YES	NO
Diabetes	YES	NO	YES	NO
Multiple sclerosis	YES	NO	YES	NO
Rheumatoid arthritis	YES	NO	YES	NO
Depression	YES	NO	YES	NO
Hepatitis	YES	NO	YES	NO
Tuberculosis	YES	NO	YES	NO
Stroke	YES	NO	YES	NO
Kidney Disease	YES	NO	YES	NO
Anemia	YES	NO	YES	NO
Epilepsy	YES	NO	YES	NO
STD	YES	NO		

Allergies/Other please list _____

If yes please explain: _____

Please list any surgeries or other conditions you have been hospitalized for including dates:

-Medications-	-Reasons for Taking-	-For How Long-	-Dosage-

In the past 3 months have you experienced?

Fever/Chills/Sweats	YES	NO	explain: _____
Unexplained weight change	YES	NO	explain: _____
Loss of energy/lethargic	YES	NO	explain: _____
Nausea/vomiting	YES	NO	explain: _____
Bowel changes	YES	NO	explain: _____
Numbness	YES	NO	explain: _____
Fainting	YES	NO	explain: _____
Dizziness/lightheadedness	YES	NO	explain: _____
Night pain	YES	NO	explain: _____
Difficulty breathing	YES	NO	explain: _____
Difficulty with urination	YES	NO	explain: _____
Sexual dysfunction	YES	NO	explain: _____
Currently pregnant	YES	NO	explain: _____
Increased stress	YES	NO	explain: _____
Depressed	YES	NO	explain: _____

Do you exercise or play sports? NO YES What and how many days per week: _____

Do you smoke? NO YES Packs/day _____ Number of years: _____

Do you drink alcohol? NO YES Drinks/day _____

How much water do you drink _____glasses/day

How well do you sleep? Great Fine Not well

Comments: _____

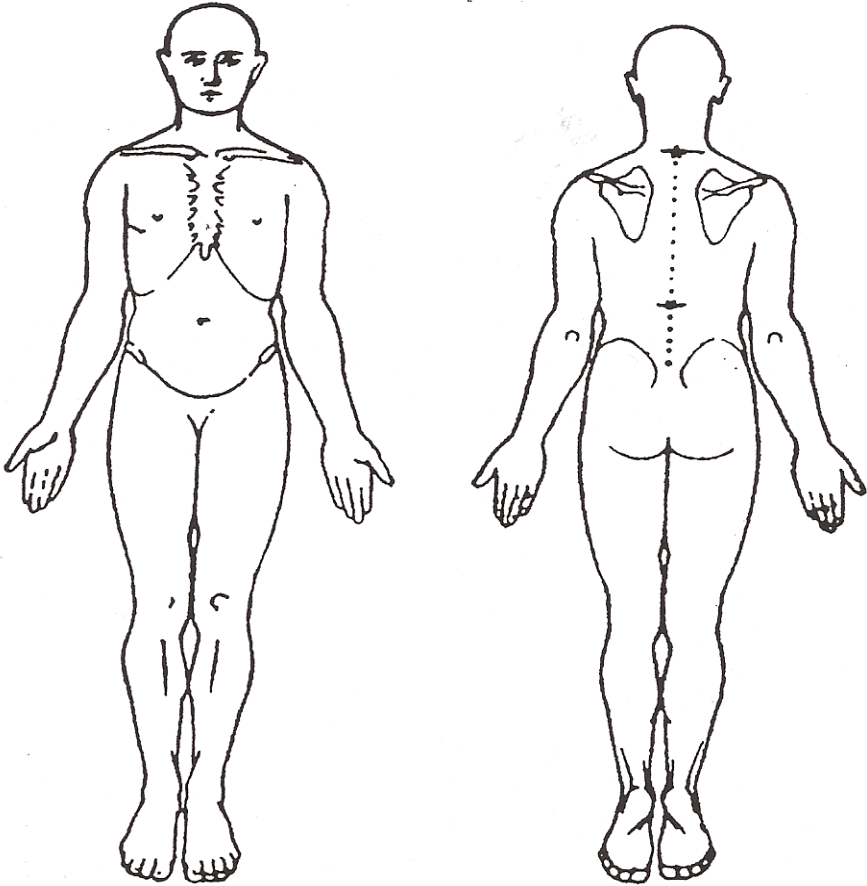
PRIVACY NOTICE

I, _____do hereby acknowledge that I have received a copy of the Privacy Notice regarding the protection of my health information with regard to the legal duties, policies and procedures of Woodstock Physical Therapy. In addition I have been informed as to the company name, address and phone number of the Privacy Officer should I have questions or complaints regarding the privacy practices of Woodstock Physical Therapy.

Signature of Patient, or Guardian _____ Date _____

The Pain Body Diagram

Please mark on the drawings below where you feel your pain.



Woodstock Physical Therapy Patient Financial Responsibility Statement

Patient Name: _____ Date of Birth: _____

In consideration of the services provided at the Practice identified above:

Please initial each statement:

_____ *If you provided us with insurance information, you are obligated to pay all in-network co-payments and deductibles at the time services are rendered. You will subsequently be invoiced for any additional amounts which are not paid by your Insurer. You have an affirmative duty to make sure that payment and/or correct information for payment is given to the Practice for reimbursement of services provided.*

_____ **I hereby assign** all medical provider benefits payable (i.e. "Payor: Insurance Coverage, Medicare, Medicaid, Social Security, etc.) and related rights existing under the Payor coverage that I have identified or will identify in connection with the services provided directly to Facility.

_____ **I hereby acknowledge** and give my express permission for Woodstock Physical Therapy to release all my patient health information, including privileged information (i.e. mental health, alcohol/drug abuse or HIV/AIDS), for payment purposes.

_____ **I understand** that any payment received by Facility for this period may be applied to any unpaid bill(s) for which I am liable.

_____ **I understand** that different insurances have different requirements for payment including, but not limited to, pre-certifications, referrals, authorizations or that the services be medically necessary.

_____ **I understand** that it is my obligation to know my Payor's requirements and ensure that they have been fulfilled.

_____ **I understand and agree that I am financially responsible for any charges not covered by this assignment and agree to pay the Practice the full balance that is not reimbursed by my medical provider benefits (certain exceptions may apply for Medicare Beneficiaries).**

_____ **I understand** that any and all balances assigned as patient responsibility may be subject to both internal and external collection efforts, as well as credit reporting to the three major credit bureaus if not paid in a timely manner.

_____ **I understand if a scheduled appointment is missed without the minimum 24 hour notice, I may be charged a \$25 "no-show" appointment fee. This is my sole responsibility and can not be billed to my insurance.**

Printed Name of Patient/Guarantor

Signature Patient/Guarantor

Date