FIRST PHYSICAL THERAPY, LLC

Get your life back!™

Welcome to First Physical Therapy! Your physician has referred you to physical therapy with a given diagnosis. Based on this referral, our therapist will perform an evaluation, develop a treatment plan, and treat your disease/injury/condition. We continually re-evaluate your progress and regularly report your progress to your physician.

Treatments are by appointment only. It is important to be prompt and keep your scheduled appointments. In consideration of other patients requiring care, we ask that you give us **24-HOUR NOTICE FOR ANY APPOINTMENT CANCELLATION.** We have voicemail for your convenience during non-working hours, weekends, and holidays. If you do not call to cancel your scheduled appointment, or call to cancel after your appointment time has passed, it is considered a "no-show".

<u>THERE IS A $20.00 CANCELLATION FEE FOR EACH MISSED APPOINTMENT AND NO-SHOW</u>

You will be personally responsible for this charge, as insurance companies do not reimburse for fees due to lack of compliance. Please note multiple cancellations/rescheduling of appointments could result in discharge from our facility.

We verify your insurance benefits as a courtesy, based solely on the information given to us over the phone or by your insurance website. This verification is not a guarantee of payment; benefits are confirmed once your insurance company has paid your claim.

All co-payments and non-covered charges are due at each visit. First Physical Therapy does not bill insurance for Durable Medical Equipment. Coinsurances and deductibles are due after insurance has processed the claim. We accept payment in the form of cash, check, MasterCard, Visa, Discover and American Express.

You signature below indicates that you understand and agree to comply with our office and payment policies.

_____ _____

Patient Signature Date

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Patient Data Sheet

Name: _____ Date of Birth: _____
Address: _____ Phone: _____
City: _____ State: _____ Zip: _____ Marital Status: S M D W
Cell Phone: _____ Email Address: _____
Employer: _____ Phone: _____
Emergency Contact: _____ Phone: _____

If Minor: Parent Name: _____ Phone: _____
Address: _____

May we leave a message on an answering machine or with a family member regarding your appointments? Y / N

Insurance Information:
Primary Insurance: _____ Name of Insured: _____
ID #: _____ Group #: _____
Address: _____
Secondary Insurance: _____ Name of Insured: _____
ID #: _____ Group #: _____
Address: _____

In the present calendar year have you received any of the following:

Physical Therapy/Occupational Therapy/Chiropractic/Acupuncture/Home Health Care (HHA)

If yes, approximate # of Visits: _____ Date of discharge (HHA): _____

- I authorize payment directly to First Physical Therapy for medical services rendered by them.
- I authorize First Physical Therapy to release all information obtained during my treatment to my insurance company, referring physician, and employer (for workers' compensation cases only).
- I understand I am responsible for all charges denied by insurance if my policy has been terminated, the service is not covered, or limits determined by my insurance company have been exceeded.
- First Physical Therapy Notice of Privacy Practices provides information about how we may use and disclose protected healthcare information about you. Copies of this notice are available in the lobby and at the front desk. I acknowledge that I have been provided access to the Notice of Privacy Practices.

_____ _____
Signature of Patient or Representative **Date**

How did you hear about us? Please circle: Physician, Friend, Internet, Chamber of Commerce, Advertisement, Other: _____

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Name: _____ Date: _____

Have you EVER been diagnosed with any of the following (check all that apply)?

- ❑cancer (type)_____
- ❑heart disease
- ❑high blood pressure
- ❑Lyme disease
- ❑pacemaker/defibrillator
- ❑osteoporosis
- ❑stroke
- ❑depression/anxiety
- ❑gallbladder disease
- ❑lung problems
- ❑thyroid disorder
- ❑arthritis (type)_____
- ❑diabetes
- ❑multiple sclerosis
- ❑kidney/liver problems
- ❑blood clots
- ❑Parkinson's disease
- ❑other_____

Please list current medications:

Are you latex sensitive? Y / N Do you smoke? Y / N _____ Packs per day

Rate your Pain Level
(0= No pain, 10= Worst pain imaginable)
Current:

0 1 2 3 4 5 6 7 8 9 10

At Best:

0 1 2 3 4 5 6 7 8 9 10

At Worst:

0 1 2 3 4 5 6 7 8 9 10

List your chief concern/complaint:

_____

What is your goal for therapy at this time?

_____

List any X-rays/MRIs/CAT Scans:

_____

List all symptoms you are currently experiencing:

_____

List any surgeries, including dates:

_____