



Welcome! Please fill out as much information as possible. If you have any questions or need any assistance please ask the receptionist. Thank you! **(HEALTH INSURANCE)**

**Confidential Patient Information**

Name (First, Middle, Last):		What do you prefer to be called?	Date
Street Address		City/State	Zip Code
Home Phone ( )	Work Phone ( )	Cell Phone/Pager ( )	
Email Address	Date of Birth	Current Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Social Security #	Method of Co-Payment/Deductible <input type="checkbox"/> Cash <input type="checkbox"/> Check <input type="checkbox"/> Credit Card		

**Health Insurance Information**

Name or Insurance Company	Billing Address	Policy # and Subscriber
Phone #:		
Name of Insured	Relationship to insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child	Insured's Employer

**How were you referred to us?**

<input type="checkbox"/> Patient Name or resource:	<input type="checkbox"/> Physician Name	<input type="checkbox"/> Primary Care Physician
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<b>Primary Care Physician:</b>	Phone #: ( )
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<b>Referring Physician name:</b>	Phone #: ( )
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**Work Status:**  Employed  Retired  Disabled  Full-time Student  Part-time Student

Employer:	Phone #: ( )	Occupation and Job Responsibilities
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Employer Address	City/State	Zip Code
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**Marital Status:**  Married  Single  Divorced  Separated  Widowed Spouse's Name \_\_\_\_\_

**Primary Language Spoken** \_\_\_\_\_ **Hand Dominance:**  Left  Right  Ambidextrous  N/A

**CONSENT OF TREATMENT OF A MINOR**

I hereby authorize Jon Dooley, MSPT and whomever he may so designate as his assistant, to administer physical therapy care as he deems necessary to my son/daughter, _____, dated _____, 20__ at Greendale Physical Therapy.	
<b>Signature:</b>	<b>Witnessed:</b>

**IN CASE OF EMERGENCY**

Who should we contact?	Relation	
Home Phone	Work Phone	Cell Phone

The reason for this visit is as a result of:  Work  Sports  Auto Accident  Trauma  Chronic  Other \_\_\_\_\_  
 Explain what happened: \_\_\_\_\_

When did you first notice this condition:
Did it begin: <input type="checkbox"/> Immediate or <input type="checkbox"/> Gradually? Briefly describe:
What is the exact location of your symptoms:
Do your symptoms spread? <input type="checkbox"/> No <input type="checkbox"/> Yes Where?
How often do you experience these symptoms? <input type="checkbox"/> Constant <input type="checkbox"/> Frequent (75% of day) <input type="checkbox"/> Often (50%) <input type="checkbox"/> Seldom (25%) <input type="checkbox"/> Rarely (less than 25%)
Is this condition progressively: <input type="checkbox"/> Worsening <input type="checkbox"/> Improving or <input type="checkbox"/> Unchanged
What is the intensity of your symptoms? <input type="checkbox"/> Slight <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Emergency
What makes your symptoms worse?
What makes your symptoms better?
Is the condition interfering with your: <input type="checkbox"/> Sleep <input type="checkbox"/> Work <input type="checkbox"/> Daily Routine If so, Explain:
Have you had this condition in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, Explain: _____
What treatment did you receive? _____
Was that treatment effective? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you sought any other treatment for your current condition? <input type="checkbox"/> Yes <input type="checkbox"/> No
If so, where and by whom?
Have you been treated by a physical therapist before? <input type="checkbox"/> Yes <input type="checkbox"/> No
If so, where and by whom?
Do you regularly exercise or work out? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, how often?

**Health History**

Are you taking any of the following medications:

- |   |  |   |                                      |
|---|--|---|--------------------------------------|
| <input type="checkbox"/> Nerve pills    | <input type="checkbox"/> Non prescription pain killers | <input type="checkbox"/> Muscle relaxes | <input type="checkbox"/> Stimulants  |
| <input type="checkbox"/> Blood thinners | <input type="checkbox"/> Tranquilizers                 | <input type="checkbox"/> Insulin        | <input type="checkbox"/> Other _____ |

**Please list any previous surgeries, serious traumas, or serious accidents, include dates if known.**

- |          |            |
|----------|------------|
| 1. _____ | Date _____ |
| 2. _____ | Date _____ |
| 3. _____ | Date _____ |

**Do you have, or have you ever had, any of the following diseases or conditions? Check all that apply:**

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> No Past Medical History    | <input type="checkbox"/> Emphysema/Glaucoma    | <input type="checkbox"/> Multiple Sclerosis      | <input type="checkbox"/> Alcohol/Drug Abuse  |
| <input type="checkbox"/> Fainting/Seizures/Epilepsy | <input type="checkbox"/> Muscular Dystrophy    | <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Frequent Neck Pain  |
| <input type="checkbox"/> Osteoporosis               | <input type="checkbox"/> Arthritis             | <input type="checkbox"/> Heart Surgery/Pacemaker | <input type="checkbox"/> Frequent Headaches  |
| <input type="checkbox"/> Blood Disorder             | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Shingles                | <input type="checkbox"/> Cancer              |
| <input type="checkbox"/> High/Low Blood Pressure    | <input type="checkbox"/> Sinus Problems        | <input type="checkbox"/> Chemotherapy            | <input type="checkbox"/> HIV+/AIDS           |
| <input type="checkbox"/> Tuberculosis               | <input type="checkbox"/> Circulation Problems  | <input type="checkbox"/> Kidney Problems         | <input type="checkbox"/> Ulcers/Colitis      |
| <input type="checkbox"/> Currently Pregnant         | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Lower Back Problems |
| <input type="checkbox"/> Difficulty Breathing       | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Other _____             | <input type="checkbox"/> Other _____         |

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform the office of any changes to the information I have provided.

Signature: \_\_\_\_\_ Date \_\_\_\_\_

## FINANCIAL AGREEMENT

**GREENDALE PHYSICAL THERAPY** accepts third party billing. We will send your insurance claims to the address provided, on a weekly basis. **It is your responsibility** to call your insurance company to check on the coverage provided by your individual policy.

**Most insurance companies require a doctor's referral**, if this is the case with your policy; you should have your physician forward the referral to our office.

**Medicare requires that you have an appointment with your physician every 30 days to be reviewed and re-certified.**

If we have not received payment from your insurance company within 30 days, we expect payment from you directly. Your insurance contract is between you and your carrier. We submit claims as a courtesy to you. **You are directly responsible for your payment of our services.** Occasionally, insurance companies may not cover certain physical therapy treatment procedure (such as, but not limited to, iontophoresis, massage, and ultrasound). If your insurance will not pay for these procedures you can choose to pay for that procedure yourself or you can decline the procedure in question. The choice is always yours. If you are unsure whether or not a procedure is covered it is your responsibility to find out. There are numerous policies and each is different so **we cannot advise you about your coverage.**

Our fees are generally considered to fall within the acceptable range by most insurance companies, and therefore are covered up to the maximum allowable determined by each carrier. This applies to companies who pay a percentage of usual, customary, and reasonable fees (UCR). Thus, most insurance companies consider our fees usual, customary, and reasonable.

This statement does not apply to all companies who reimburse based on arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.

***GREENDALE PHYSICAL THERAPY RESERVES THE RIGHT TO CHARGE A FEE OF \$25  
FOR MISSED APPOINTMENTS THAT ARE NOT CANCELLED.***

THIS CHARGE WILL BE TO YOU, THE CLIENT OR RESPONSIBLE GUARDIAN, NOT YOUR INSURANCE COMPANY.

WE ALSO RESERVE THE RIGHT TO **REFUSE TREATMENT** FOR ANY CLIENT THAT HAS FAILED TO SHOW FOR THREE OR MORE APPOINTMENTS.

For **account in litigation**, we will bill your health/auto insurance directly. Please be advised that **you are responsible** for payment of your bill, not the individual being sued. Liability action against someone else will not enable you to refuse payment to us.

If you would like to submit your own claims to your insurance company, we will require payment at the time of the treatment.

**\*\*\*Patients with a co-pay are required to make payment at the time of treatment.\*\*\***

If during the course of treatment your insurance company changes, **please** let us know **immediately**.

If you have any questions, please feel free to ask the receptionist.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_