



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

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 #				

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

Workman's Compensation Insurance Information

Name or Insurance Company	Billing Address	Has your employer been notified? <input type="checkbox"/> Yes <input type="checkbox"/> No Date Of Injury: __/__/__
Phone #: ()		
Utilization Review (UR) Nurse	UR Phone #	UR Fax #
Employers Name	Claim #	Claims Adjuster Phone #: ()

How were you referred to us?

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

Employer: Phone #:	Occupation and Job Responsibilities	
Employer Address	City/State	Zip Code

Marital Status: Married Single Divorced Separated Widowed Spouse's Name_____

Primary Language Spoken_____ **Hand Dominance:** Left Right Ambidextrous N/A

IN CASE OF EMERGENCY

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

Accident Information

Date of Accident?	Was the accident reported? <input type="checkbox"/> Yes <input type="checkbox"/> No When?
Where did the accident occur? Street/Town etc.	
Details of the accident	
Please list the symptoms you felt immediately after the accident?	
Please describe the pain and its location.	
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%)	
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:	
Where were you taken after the accident?	Where you taken to the Hospital by <input type="checkbox"/> Ambulance <input type="checkbox"/> Private Vehicle <input type="checkbox"/> Other
Where X-ray taken? <input type="checkbox"/> Yes <input type="checkbox"/> No	MRI? <input type="checkbox"/> Yes <input type="checkbox"/> No Catscan? <input type="checkbox"/> Yes No
Give the dates you missed work as a result of the accident.	
Additional Information:	
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 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?	

Does your work involve: (check all that apply)

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Prolonged Sitting | <input type="checkbox"/> Prolonged Standing | <input type="checkbox"/> Prolonged Walking | <input type="checkbox"/> Prolonged Driving |
| <input type="checkbox"/> Prolonged Forward Bending | <input type="checkbox"/> Exposure to Vibrating Tools | <input type="checkbox"/> Exposure to Temperatures | <input type="checkbox"/> Frequent Typing |
| <input type="checkbox"/> Working With a Bent Neck | <input type="checkbox"/> Repetitive Overhead Work | <input type="checkbox"/> Excessive Reaching | <input type="checkbox"/> Frequent Hand Grasp |
| <input type="checkbox"/> Climbing Ladders | <input type="checkbox"/> Excessive Stair Climbing | <input type="checkbox"/> Lifting Light Objects | <input type="checkbox"/> Lifting Heavy Objects |
| <input type="checkbox"/> Carrying Light Objects | <input type="checkbox"/> Carrying Heavy Objects | <input type="checkbox"/> Repetitive Pushing/Pulling | <input type="checkbox"/> Rep. Arm Motions |
| <input type="checkbox"/> Repetative Foot Motions | <input type="checkbox"/> Other_____ | <input type="checkbox"/> Other_____ | <input type="checkbox"/> Other_____ |

Health History

Are you taking any of the following medications:

- Nerve pills Non prescription pain killers Muscle relaxes Stimulants
- Blood thinners Tranquilizers Insulin 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:

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

We do require a lien on your settlement (a promise to pay), which it is ultimately the patient's responsibility to sign and file with their attorney (If applicable), and return to our office within one week after starting physical therapy. To expedite the process, GPT may on your behalf forward these documents to your attorney. However, in the event that we are not able to obtain a signed lien, the patient will be notified to pursue and file the said lien with their lawyer.

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: _____