PATIENT INFORMATION SHEET

Name _____ Parent (if minor) _____

Address _____ Town _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

SS# _____ DOB _____ Age _____ Marital Status _____ Sex _____

Please indicate below how you were referred to our office:

*Referred by _____ Number _____

*Referring Physician's Name _____ Number _____

Address _____

Is the Patient Working? Yes_____ No_____

Did the injury occur at: WORK / SCHOOL / CAR ACCIDENT / OTHER

Do you have an attorney? Yes____ No_____

If yes, name of Attorney _____ Phone Number _____

PATIENT INFORMATION SHEET

Type of Insurance:

Private_____ Compensation _____ No Fault _____

PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Company_____	_____
Address_____	_____
_____	_____
Phone Number_____	_____
Insurance Policy No. _____	_____

NO FAULT INSURANCE:

Date of Accident_____ No Fault Claim #_____

Insurance Carrier _____ Policy # _____

Address _____ Adjuster Name_____

_____ Adjuster Phone #_____

Adjuster Fax #_____

WORKERS COMPENSATION INSURANCE:

Date of Injury_____ Date of Surgery_____ WCB CASE # _____

Insurance Carrier _____ Carrier Case # _____

Address_____ Adjuster Name_____

_____ Adjuster Phone #_____

Employer_____ Adjuster Fax #_____

Employer Address/Phone_____ _____

SCHOOL INSURANCE:

Name of School_____ Date of Injury_____

Has an injury report been filed? Yes / NO

If so, please provide us with the original signed copy and School Insurance Form.

HISTORY: PLEASE D[illegible]IBE YOUR PAIN AS BEST YOU C[illegible]N THE DRAWINGS BELOW:

LOCATION OF PAIN OR OTHER SYMPTOMS:

_____

_____

_____

ON A SCALE FROM 0-TO-10, HOW SEVERE IS THE PAIN, (10 BEING THE WORST)

1 2 3 4 5 6 7 8 9 10 _____

HOW OFTEN IS THE PAIN

_____

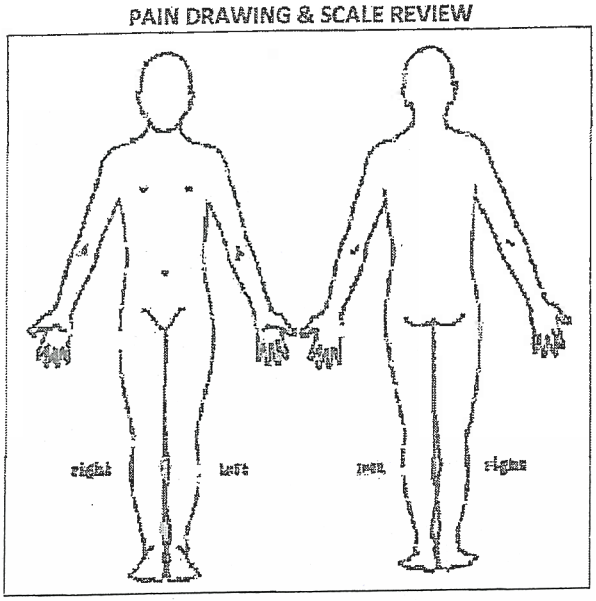
IS THE PAIN REFERRED TO ANOTHER PART OF YOUR BODY?

_____

SENSATION:

_____

PAIN DRAWING & SCALE REVIEW



HOW LONG HAVE YOU HAD THIS PROBLEM? _____

WHAT KIND OF NON-SURGICAL TREATMENT HAVE YOU HAD TO DATE? _____

_____

PHYSCIAL THERAPY? _____ YES / NO , IF YES HOW OFTEN? _____

CHIROPRATIC CARE? _____ YES / NO , IF YES HOW OFTEN? _____

ACCUPUNCTURE? YES / NO , IF YES HOW OFTEN? _____

MEDICATIONS? _____

NONE: _____

ANTI-INFLAMMATORY: _____ WHICH? _____

MUSCLE RELAXANTS: _____ WHICH? _____

PAIN KILLERS: _____ WHICH? _____

ANTI-DEPRESSANTS: _____ WHICH? _____

EPIDURAL STERIOD INJECTIONS: _____ YES / NO _____ HOW MANY TIMES? _____

Movement Concepts Physical Therapy

Responsibility Form Patient Guarantor & Financial

Welcome to Movement Concepts Physical Therapy. Thank you for choosing our facility to help serve you with quality and personalized care for your rehabilitation needs. Please read the following information to help you understand your financial responsibilities. Your signature on this form indicates that you accept the following statements.

Arrival: Please arrive on time for all appointments. If you are going to be late please call.

Scheduling: Please schedule your next appointment(s) as you check in.

Cancellation: If you are unable to attend a treatment session, please notify us at least twenty-four hours prior to your appointment time.

Patient / Guarantor Responsibility: Payment for all professional services rendered is the responsibility of the patient, parent or guardian. Movement Concepts PT. will assist in the preparation of insurance forms to help expedite insurance payments and verify your benefits. **The patient is responsible, however, for all fees regardless of insurance coverage.** You are responsible for payment of any deductible, co-payment, and co-insurance as stated by your contract with your insurance carrier. If your insurance carrier denies any part of your claim, or, if after consulting with your physician, the need exists to continue therapy beyond the approved coverage by your insurance carrier, you will be responsible for your account balance in full. If it is necessary to refer the account to our collection attorneys, the patient agrees to pay the cost of all collection fees including attorney's fees.

I, hereby guarantee payment of all charges incurred for my course of treatment or otherwise not covered by my insurance carrier to Movement Concepts Physical Therapy.

CONSENT FOR CARE AND TREATMENT

I, hereby agree and give consent to Movement Concepts Physical Therapy to furnish medical care and treatment necessary and proper in diagnosing or treating his/her physical condition.

HEALTH NSURANCE PORTABILITY AND ACCOUNTABILITY ACT

I authorize my medical information to be released to the following:

1. Primary Care Physicians, other Physicians & Medical Staff involved in our care
2. Physical Therapists & Occupational Therapists involved in your care
3. School Nurses involved in your care
4. Orthotists involved in our care
5. Athletic Trainers & coaches involved in your care
6. Worker's Compensation Physicians, Nurse's, and Case Managers involved in your care
7. Insurance Companies and/or other Payer's involved in your case
8. Attorney's involved in your case

Are there any privacy Issues that we need to be aware of? YES / NO

I make the following request for confidential communications:_____

_____

Movement Concepts Physical Therapy has made available for review a copy of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) with regard to the use and/or disclosure of certain protected health information about me.

PATIENT NAME: (Please Print)_____

PATIENT SIGNATURE:_____ **Date:**_____

(Guarantor's signature if patient is not the guarantor)