elliott
PHYSICAL THERAPY

THERAPIST: _____ **DATE/TIME:** _____

PATIENT INFORMATION

Patient Name _____ Referring Physician _____
Address _____ City _____ State _____ Zip _____
Phone _____ Primary Care Physician _____
Date of Birth _____ Diagnosis/Injury _____
Email Address _____ Preferred Pronoun(s) _____
Emergency Contact _____ Relation _____
Emergency Contact Phone: _____
Have you had Physical Therapy this year? _____ How did you hear about us _____

HEALTH INSURANCE INFORMATION

PRIMARY
Insurance Co. Name _____
ID # _____
Subscriber's Name (if other than self) _____
Subscriber's Date of Birth _____
Relationship to pt.: Spouse ____ Parent ____ Other ___

SECONDARY
Insurance Co. Name _____
ID # _____
Subscriber's Name (if other than self) _____
Subscriber's Date of Birth _____
Relationship to pt.: Spouse _____ Parent _____ Other _____

WORKMAN'S COMPENSATION INFORMATION

Insurance Co. Name _____ Claim # _____
Adjustor _____ Phone _____ Ext _____
DOI _____ Employer _____ Phone _____
City _____ State _____ Zip _____
UR Phone _____ UR Fax _____

AUTOMOBILE INSURANCE INFORMATION

Insurance Co. Name _____ Claim # _____
Adjustor _____ Phone _____ Ext _____
DOI _____ State _____ Name of Insured (if different): _____
Attorney _____ Attorney's Phone # _____

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Could you be pregnant? YES NO

Do you know or have you ever had any of the following: (please check all that apply)

	Y	N		Y	N		Y	N
Alzheimer's	___	___	Muscular Dystrophy	___	___	Vascular Disease	___	___
Heart Disease	___	___	Obesity	___	___	Shortness of Breath	___	___
Stroke	___	___	Osteoarthritis	___	___	Kidney/Bladder Problems	___	___
Current Infection	___	___	Parkinson's Disease	___	___	Previous Surgeries	___	___
Diabetes Type 1	___	___	Rheumatoid Arthritis	___	___	Metal Implants	___	___
Diabetes Type 2	___	___	Head Injury/Concussion	___	___	Pacemaker	___	___
Fibromyalgia	___	___	Headaches	___	___	Heart Attack	___	___
Previous Fractures	___	___	Seizures/Epilepsy	___	___	Osteoporosis	___	___
High Blood Pressure	___	___	Multiple Sclerosis	___	___	Recent Weight Loss/Gain	___	___
History of Cancer	___	___	Anxiety	___	___	Tobacco Use	___	___
Huntington's Disease	___	___	Depression	___	___	Anemia	___	___
Immunosuppression	___	___	Sensitivity to Hot/Cold	___	___	Hearing Loss	___	___
Lupus	___	___	Asthma	___	___	Substance Abuse	___	___

Other: _____

If you answered "YES" to any of the above, please explain and give approximate date(s):

_____

_____

_____

Are you presently taking any medications? If "YES", list all medications:

_____

_____

The information above is correct to the best of my knowledge.

_____ _____

Patient/Parent/Legal Guardian Signature Date

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The following are our office policies. ***Please read carefully*** *before signing, and be sure to ask questions you might have prior to signing this document.*

As a condition of my treatment by Elliott Physical Therapy I, _____, agree to the following:

- I am responsible for understanding my own insurance coverage. I agree to contact my insurance carrier to find out if my treatment is covered and to take such steps as required to qualify my treatment for coverage. I agree to inform Elliott Physical Therapy of any changes to my insurance.
- I agree to pay any over-the-counter financial responsibility as indicated by my insurance at every visit.
- We request a 24 hour notice in the event of a cancellation. Our intention is to develop a plan of care and schedule to help you get better in a timely fashion. If you are unable to follow your plan of care please have a discussion with your therapist.
- If my check is returned to Elliott Physical Therapy for insufficient funds, I agree to pay applied bank charges in addition to the amount of the check.

Consent to Treat/Informed Consent

- I authorize Elliott Physical Therapy to evaluate and treat my injury and perform any therapeutic procedure or treatment that is consistent with my diagnosis. I understand and am informed that, as in the practice of medicine, physical therapy may have some risks and my condition may worsen on rare occasions. No guarantee or promise has been made to me concerning the results of treatment. I understand that I can terminate any treatment at any time if I so desire.
- I authorize Elliott Physical Therapy to release information relative to any outpatient physical therapy administered to any third-party payor(s) financially responsible for these services or to my referring physician and/or primary care physician.
- I have read and understand the "Notice of Privacy Rights and Practices" (HIPAA) form.

Consent to Treat A Minor

- As the parent/guardian, I give consent to treat my child without my presence.

Payment Guarantee

In consideration of the services rendered and to be rendered by Elliott Physical Therapy, I expressly guarantee payment of my account and agree to pay any charges left unpaid in whole or in part by my insurance carrier, and that I am ultimately responsible for account totals and balance regardless of the disposition of the insurance carrier.

Assignment of Benefits

- I authorize payment directly to Elliott Physical Therapy for services rendered.
- My insurance benefits were fully explained to me and I understand what they are. I understand that I am ultimately responsible for the cost of my treatments. If my insurance company refuses to pay, for any reason, for a service that I have received, I am responsible for the charges of those sessions.

_____ _____

Patient/Parent/Legal Guardian Signature Date