

**Patient Information**

**First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M/I: \_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_ □ Male / □ Female**

**Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**E-Mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Out of State**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you currently receiving or recently received Home Health Services of any kind? □ Yes / □ No**

**If yes, when and by whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Were you discharged? □ Yes / □ No If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you currently receiving Massage Therapy or Chiropractic care? □ Yes / □ No**

**Have you had Physical Therapy, Speech Therapy, or Occupational Therapy this year? □ Yes / □ No**

**If yes, what facility? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of Visits? \_\_\_\_\_\_\_\_\_\_\_**

**How did you find out about our facility?**

**□ Physician □ Friend □ Website □ Social Media**

**Present Condition:**

**Injury/Onset Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Surgical History - Surgery related to diagnosis? □ Yes / □ No**

**If yes, Date of Surgery: \_\_\_\_/\_\_\_\_/\_\_\_\_ Type of Surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you recently been hospitalized for current condition? □ Yes / □ No Date: \_\_\_\_/\_\_\_\_/\_\_\_\_**

**Recent Diagnostic Testing / Imaging? If so what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What is your primary concern / chief complaint / diagnosis? (Reason you are here today):**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What are your current limitations? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you have pain? If so, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Rate your Pain: (0=None – 10=Extreme)**

**Current: \_\_\_\_\_\_\_\_\_\_ at worst: \_\_\_\_\_\_\_\_\_\_ at best: \_\_\_\_\_\_\_\_\_\_**

**Pain Description:**

**□ Burning □ Sharp □ Dull / Achy □ Throbbing □ Shooting**

**□ Numbness / Tingling □ Constant □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you fallen in the last year? □ Yes / □ No**

**Why did you fall?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you pregnant? □ Yes / □ No**

**Do you have a pacemaker? □ Yes / □ No**

**Past Medical History - check all those apply:**

* **Parkinson’s**
* **Rheumatoid Arthritis**
* **Ringing I ears**
* **Seizures**
* **Shortness of Breath**
* **Stroke**
* **Other \_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Asthma**
* **Cancer \_\_\_\_\_\_\_\_\_\_**
* **Chest Pain**
* **Chronic Bronchitis**
* **Diabetes 1 or 2**
* **Dizziness**
* **Emphysema**
* **Heart Attack**
* **Heart Disease**
* **Hepatitis**
* **Hernia**
* **Hypoglycemia**
* **Hypertension**
* **IBS**
* **Joint Replacements**
* **Kidney Disease**
* **Liver Disease**
* **Multiple Sclerosis**
* **Osteoarthritis**
* **Osteoporosis**
* **Polio**

**Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_\_\_\_\_\_Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Current medications & dosage (If you have a medication list, we will be happy to make a copy):**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Drug** | **Dosage / Frequency** | **Name of Drug** | **Dosage / Frequency** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**I certify that the above information is true and complete to the best of my knowledge. I authorize Request Physical Therapy and its staff to provide treatment for myself or the minor patient named above.**

**Print Name:**

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

**PATIENT ASSIGNMENT OF BENEFITS / AUTHORIZATION**

**AND FINANCIAL RESPONSIBILITY DISCLOSURE STATEMENT**

**Consent to Use Protected Health Information for Purposes of Treatment, Payment, and Healthcare Operations** – I consent to the use and/or disclosure of my protected health information (PHI) by Request Physical Therapy, Inc. (Request PT) for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct healthcare operations of Request PT. I understand that diagnosis or treatment of me by Request PT may be conditioned upon my consent as evidenced by my signature on this document.

**Assignment of Benefits** – I hereby assign any and all medical benefits to which I am entitled through my current insurance plan/plans to Request PT, 2601 Manatee Ave. W., Suite E, Bradenton, FL 34205. This assignment shall stay in effect until revoked by me in writing. A copy of this assignment is considered as valid as the original.

**Financial Responsibility** – I understand that I am responsible for all charges, whether or not I have insurance. In the event I have insurance with a plan that has a participation agreement with Request PT, I understand that I am responsible for all deductibles, co-payments, and co-insurances. In the event that I do not have insurance with a plan that has a participation agreement with Request PT, I understand that I am responsible for the full difference between Request PT billed charges and any amount paid by the insurance unless a payment arrangement is negotiated with the Request PT billing department.

**Consent for Use and Disclosure of PHI** – I understand that by signing this consent form, I am giving my consent to Request PT to use and disclose my protected health information to carry out treatment, payment activities, and health care operations. I have had full opportunity to read the Request PT Notice of Privacy Practices. This PHI is being used or disclosed for the purpose of expediting communication of my treatment and care and shall remain in full force and effect for twelve months from the date recorded below. I understand that I have the right to revoke this authorization in writing at any time by sending such written notice to the practice’s Privacy contact at 2601 Manatee Ave. W., Suite E, Bradenton, FL 34205. I understand that such revocation will not affect any previous claims submission or payments from my insurance provider for dates of service prior to my written notice.

**Cancellation / Now Show Policy** – Request Physical Therapy understands that there are times when you must miss an appointment. Please understand that we (Request Physical Therapy) reserves the right to charge a $ 25 dollar cancellation fee if an appointment is not cancelled at least 24-hours in advance.

**Indicated below are individuals whom Request PT may speak to regarding my treatment. Please enter the name of the individual in the space provided.**

* Spouse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Family Member: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do we have your permission to leave a confidential message at the phone number(s) you provided to us?**

□ Yes □ No □ Home □ Mobile

**My insurance benefits have been explained to me. I understand that I am responsible for knowing the details of my insurance benefits and agree to pay any charges which my insurance does not pay.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient / Guardian / Responsible Party Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name of Patient/Guardian/Responsible Party Relationship to Patient (if applicable)