**Patient Information**

**PATIENT’S FIRST NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MIDDLE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ LAST: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AGE: \_\_\_\_\_\_\_ MALE FEMALE SSN#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HOME PHONE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CELL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WORK: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CITY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE: \_\_\_\_\_\_ ZIP: \_\_\_\_\_\_\_\_\_\_\_\_**

**OUT OF STATE ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_\_\_\_**

**EMAIL ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**IN CASE OF EMERGENCY, NOTIFY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PH#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**MARITAL STATUS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**OCCUPATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**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 US?**

* **PHYSICIAN**
* **PATIENT**
* **WEBSITE**
* **OTHER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**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 of Hospitalization: \_\_\_\_/\_\_\_\_/\_\_\_\_**

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

**What is your Primary Concern/Chief Complaint / Diagnosis? (Reason you are here today): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**Functional Limitations (Please circle all that you have difficulty with or cannot do):**

**Self-Care Reaching Pushing Pulling Lifting Carrying Sitting Standing Bending**

**Squatting Walking Sleep Bed Mobility Transferring out of Bed Transferring out of chair**

**Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Pain Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Rate your Pain: 0 = None 5 = Moderate 10 = Extreme emergency room**

**Pain at Worst: \_\_\_\_\_\_\_\_\_\_ Current\_\_\_\_\_\_\_\_\_\_ and at Best: \_\_\_\_\_\_\_\_\_**

**Pain Description: (Please circle what best describes your pain):**

**Burning Sharp Dull/Achy Throbbing Shooting Numbness/Tingling Constant Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you fallen in the last year? Yes No Why or how did you fall?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you / are you:**

**Smoke: Yes No How Often: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Drink Alcohol: Yes No How Often: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Pregnant: Yes No How Long: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Pace Maker: Yes No Date received: \_\_\_\_\_\_\_\_\_\_\_**

**Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

* **Asthma**
* **Cancer \_\_\_\_\_\_\_\_\_\_**
* **Chest Pain**
* **Chronic Bronchitis**
* **Diabetes 1 or 2**
* **Dizziness**
* **Emphysema**

* **Joint Replacements**
* **Kidney Disease**
* **Liver Disease**
* **Multiple Sclerosis**
* **Osteoarthritis**
* **Osteoporosis**
* **Polio**
* **Heart Attack**
* **Heart Disease**
* **Hepatitis**
* **Hernia**
* **Hypoglycemia**
* **Hypertension**
* **IBS**
* **Parkinson’s**
* **Rheumatoid Arthritis**
* **Ringing I ears**
* **Seizures**
* **Shortness of Breath**
* **Stroke**
* **Other \_\_\_\_\_\_\_\_\_\_\_\_\_**

**ALLERGIES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HEIGHT:\_\_\_\_\_\_\_\_\_ WEIGHT:\_\_\_\_\_\_\_\_\_\_ BMI *(THERAPIST WILL CALCULATE)*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MEDICATIONS YOU ARE TAKING WITH DOSAGE (IF YOU HAVE A LIST, WE CAN MAKE A COPY):\_**

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

**Non-Prescription Medications or Supplements: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**What are your Goals for Physical Therapy? : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

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

**Guarantee of Payment**

If you have insurance coverage, we will file to your insurance company. Please notify this office if special financial arrangements are necessary. You will be responsible for any cost incurred on overdue balances including, but not limited to, late fees, interest fees, NSF fees and collection agency fees.

If your insurance coverage changes please let our office know as soon as possible as **Request Physical Therapy is not participating with all plans.**

**Your Physical Therapy Benefits Explained:**

**Your insurance company does not guarantee payment until the claim is processed. The following is a guideline given to us and if your actual bill differs from the following you will need to contact your insurance company.**

You have Medicare as a Primary Insurance and an additional Supplemental / Secondary Insurance.

If either of your Insurances requires you to pay a percentage (%) or a Deductible you will be

billed at a later date.

You have Medicare as a Primary Insurance but NO Supplemental / Secondary Insurance.

You are responsible for 20% of the allowed charges and will be billed at a later date.

Your Copay per visit is $ .

Your health insurance contract arrangements state you are responsible for %

of the allowable charges.

Your health insurance contract arrangements state you are responsible for a $ \_\_\_\_\_\_ deductible.

Self-Pay: Evaluation agreed amount: $\_\_\_\_\_\_\_. Additional visit(s) agreed amount: $\_\_\_\_\_\_\_.

You agree to pay $\_\_\_\_\_\_\_\_\_ towards deductible or coins at every visit

You have Automobile Insurance. You will be responsible for \_\_\_\_\_\_\_\_% of the allowed charges.

Name of Motor Vehicle Insurance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Claim Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Adjuster’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have an Attorney? ( ) Yes ( ) NO Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**My insurance benefits have been explained to me. \_\_\_\_\_\_\_\_\_**

**Patients Initials Date**

**I agree to pay any charges, which my insurance does not pay. \_\_\_\_\_\_\_\_\_**

**Patients Initials Date**

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

**Patient 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.

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

* My Spouse \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Family Member \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Patient’s Non-Custodial Parent \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

* Yes: (Circle all that apply) Home Mobile Work Other\_\_\_\_\_\_\_\_\_\_\_\_\_
* No

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

Signature of Patient/Guardian/Responsible Party Date

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

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