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
- Heart Attack
- Heart Disease
- Hepatitis
- Hernia
- Hypoglycemia
- Hypertension
- IBS
- Joint Replacements
- Kidney Disease
- Liver Disease
- Multiple Sclerosis
- Osteoarthritis
- Osteoporosis
- Polio
- 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

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)