restore
PHYSICAL THERAPY

GENERAL INFORMATION:

First Name: _____

Middle Name: _____

Last Name: _____

Preferred Name: _____

SSN: _____ - _____ - _____ **(optional)**

Birthdate: _____ / _____ / _____

Gender: Male/Female

Pronouns: He/Him, She/Her, They/Them, Prefer Not to Say

MINOR:

Parent/Guardian Name: _____

Address: _____

Phone: _____

Birthdate: _____ SSN: ____ - ____ - ____

Employer: _____

CONTACT INFORMATION:

Primary Phone: _____ Cell/Home/Work

Secondary Phone: _____ Cell/Home/Work

Email: _____

Appointment Text Reminder*: ◯

***Note by checking the text reminder box you authorize certain PHI to be disclosed (ie: name, email, appointment information)**

Physical Address: _____

City: _____ State: _____ Zip: _____

Billing Address: _____

EMERGENCY CONTACT:

Name: _____Phone: _____

Address: _____

Relation: _____

REFERRING PHYSICIAN & FACILITY:

_____

Date of Surgery (if applicable): _____

Do you have a follow-up appointment with the doctor who referred you to physical therapy?

o YES, date of appointment: _____

o NO, I am to call the doctor to schedule a follow up

o NO, doctor did not request to see me again

Please complete the following as applicable:

Occupation: _____ Employer: _____

Phone: _____

Business address: _____

MARITAL STATUS: Single/Married/Widow/Divorced

Spouse Name:_____

Employer: _____Ph: _____

INSURANCE INFORMATION:

Primary Insurance: _____

ID#: _____ Group#: _____

Insurance Phone: _____

Claims Address: _____

Secondary Insurance:_____

ID#: _____ Grp#_____

Insurance Phone: _____

Claims Address: _____

◯ **Motor Vehicle Accident** ◯ **Workers' Comp**

If yes, Date of injury: _____ State: _____

Claim #: _____

Restore Physical Therapy is committed to providing quality physical therapy at reasonable cost. It is our policy to collect all accounts receivable within 90 days from date of service.

For those patients with insurance coverage, we bill regularly. ***However, the patient is responsible to understand the specifics of their individual insurance coverage.*** **The insurance contract is between the covered individual and the insurance company.** The patient retains ultimate responsibility for financial charges incurred as a result of treatment. Our staff is available for assistance with insurance billing questions.

CONSENT FOR TREATMENT

I hereby consent to such physical therapy procedures as may be rendered by Restore Physical Therapy. There is also consent for authorization of all insurance benefits to be paid directly to Restore Physical Therapy, and assumption of all financial responsibility for the balance of charges not included in the insurance coverage. A $20.00 fee will be charged for returned checks. Restore Physical Therapy has the authority to disclose medical information for treatment, payment and health operations. Restore Physical Therapy is released from disclosure of the patient's records as provided by this paragraph.

_____

Patient or Guardian Signature **Date**

restore
PHYSICAL THERAPY

Please describe your main problem: _____

_____

_____

When did it begin?_____ **Is it getting** *(circle one)*: better / worse / staying the same

What prior treatment have you received? *(chiropractic, massage, etc.)* _____

_____

What makes it worse? _____

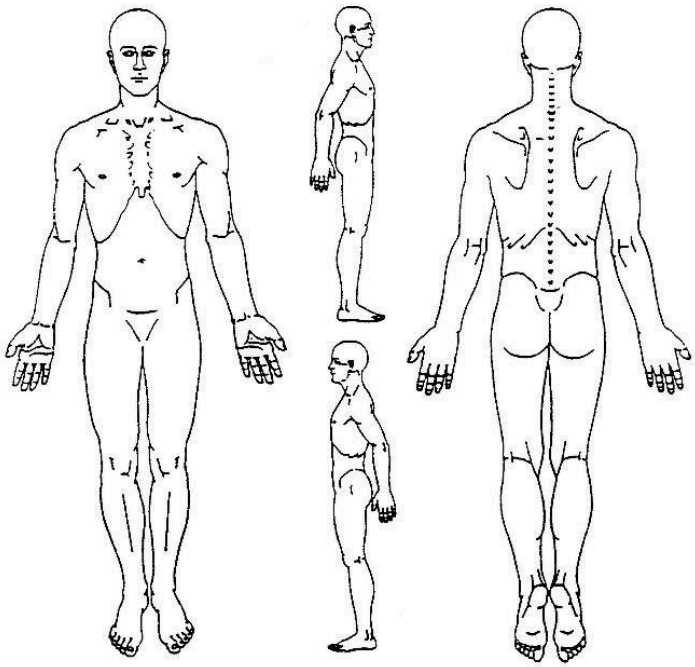
What makes it better? _____

Medical History:

Do you have any of the following:

Cancer	
Diabetes	
Osteoarthritis	
Rheumatoid Arthritis	
Osteoporosis	
Headaches	
Ringing in Ears	
Hypoglycemia	
High Blood Pressure	
Heart Disease	
Pacemaker	
Lung Disease	
Neurological Condition (MS, Parkinson's, CVA/Stroke)	
Thyroid Condition	
Dizziness/Fainting	
Fevers/Chills	
Unexplained Weight Changes	
Bowel/Bladder Issues	
Urine Leakage	
Pelvic Pain	
Other Conditions	

Please indicate below where your symptoms are located:



KEY:

numbness: ====

pins & needles: 0000

stabbing pain: / / / /

burning pain: XXXX

Pain level (0-10, 0=no pain, 10=worst pain):

Current: ____ / 10

At best: ____ / 10

At worst: ____ / 10

restore
PHYSICAL THERAPY

If you answered yes to any of the questions on the previous page, please explain here:

_____

_____

Do you have any allergies? *(circle one)* Yes / No

Please explain: _____

_____

Are you currently taking any medication/supplements? *(prescription or over-the-counter)* Yes / No

If yes, please list medications or attach a separate page with the list.

Medication name: **Dosage/ frequency** **Route (i.e.: oral, cream)**

_____

_____

_____

_____

_____

_____

_____

Have you had any falls in the past 12 months? *(circle one)* Yes / No

If yes, how many? _____ Were you injured in the fall(s)? Yes / No

What activities/exercise do you currently participate in? *(running, swimming, yoga, golf, etc)*

_____

_____

Which activities or tasks would you like to be able to perform that you can't currently do because of your current concern?

_____

_____

_____

Any additional comments or concerns not addressed in this questionnaire?

_____

_____

restore
PHYSICAL THERAPY

APPOINTMENTS

Your Copay or Coinsurance amount is due at the beginning of your appointment. Please notify the front office of any address, phone number or insurance changes.

LATE ARRIVALS

In order to remain on schedule for all our patients, we may shorten your appointment time if you are late to your appointment. Your Copay or Coinsurance amount will still be due.

As a courtesy to others, if you arrive more than 10 minutes late to your scheduled appointment, you will be asked to reschedule and this will incur a $50 late cancellation fee.

LESS THAN 24-HR CANCELLATION / NO SHOW

We do charge the patient, not the insurance, a **$50 fee** for cancellations less than 24-hour notice and/or if you do not show for your appointment. After 2 no shows, all future appointments will be canceled. After 2 late cancelations, we will move to a “one appointment at a time” basis. You will be discharged as a patient if you have 3 cancellations less than 24-hours and/or 2 no show appointments.

HIPAA NOTIFICATION

I acknowledge that I have been informed and notified of the whereabouts of Restore Physical Therapy’s notice of information practices (how medical information regarding myself may be used and disclosed and how I can get access to this information).

By signing this, I agree to and understand the policies Restore has outlined above.

_____

Patient or Guardian Signature Date