United Physical Therapy

Date:_____ Patient ID#:_____Therapist:_____

Patient's Name:_____
Last First M.I.

Mailing Address:_____
Street City State Zip

Birth Date:_____ Sex: Male Female Marital Status:_____
(Please Circle One)

Employer:_____ Email Address:_____

Home #:_____ Work #:_____ Mobile #:_____

Would you like a reminder of future appointments? Yes No
(Please Circle One)

If so, would you prefer a: Call Text E-Mail Date of Injury/Onset:_____
(Please Circle Only One)

Body part(s) to be treated:_____

Is this work related? Yes No Is this related to an Auto Accident? Yes No
(Please Circle One) (Please Circle One)

Referring Provider:_____

Person we can contact in the event of an emergency:

Name:_____ Phone #:_____

Relationship to patient: _____

I plan to make a payment of any non-covered medical costs by: ( )Cash/Check ( )Master Card ( )Visa

<u>If you are not the subscriber on your insurance, please complete the following section with subscriber's information:</u>

Name:_____ Birth Date:_____

Mailing Address:_____
(If different than patient) Street City State Zip

Home #:_____ Work #:_____ Mobile #:_____

Employer:_____ Relationship to patient: _____

I authorize the release of any medical information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. I authorize payment of medical benefits to physician or supplier for service:

Signed:_____ Date: _____
(Insured or Authorized Person)

Welcome to United Physical Therapy!

Here is some important information you should know as a new patient:

1. It is your responsibility to notify your insurance company you will be attending physical therapy. We recommend you also inquire about your carrier's specific coverage. We do precertification with your insurance as a courtesy. Any charges not covered by insurance, **including treatment your insurance company deems not medically necessary, will be your financial responsibility.** United Physical Therapy is not responsible for tracking insurance benefits. You are responsible for any deductible or co-payment at the time of service.
2. **If your out of pocket expenses are 90 days or more past due, your account will be turned over to collections.** You will be responsible for the account balance plus an additional 32% to cover the cost associated with collections.
3. It is your responsibility to notify United Physical Therapy of any changes to your insurance carrier or plan. **If you do not provide us with the correct insurance information at the time of your appointment, you will be financially responsible** for the resulting unpaid bills.
4. United Physical Therapy **does not** bill health insurance for supplies. If supplies are suggested for your benefit, they may be purchased over the counter here or your therapist can suggest a location to purchase them.
5. If you cancel without 24 hours notice and/or "no show" for a total of three appointments, the therapist may choose not to see you as a patient any longer.
6. Please note children must be accompanied by an adult at all times. They can be brought to the treatment room or accompanied in the waiting room. Please no children in the gym area.

****When you arrive, please sign in even if you are not a new patient.****

In the future, if there are any changes with your name, address, phone numbers, or insurance, please let the receptionist know.

I have read and I understand the above guidelines.

Signature: _____ Date:_____

United Physical Therapy Return Policy:

Due to company policy, United Physical Therapy does not accept returns on any medical supplies sold through our clinic; this policy stands whether the item has been opened or not. Please sign and date this document below acknowledging you understand that there are no refunds or exchanges on any supplies purchased through United Physical Therapy.

Please be aware that this acknowledgment will be scanned into your record and this policy stands throughout your tenure of care at United Physical Therapy.

Name: _____ Date: _____

Facility Name: United Physical Therapy

By signing below, I acknowledge that I have received, or have had the opportunity to receive, a copy of United Physical Therapy's Notice of Privacy Practices ("Notice"); which describes how my health information is used and shared. I understand that United Physical Therapy ("UPT") has the right to change this Notice at any time. I may obtain a current copy by contacting the Facility Privacy Official, or by visiting the UPT web site at www.unitedpt.com

Signature of Patient or Personal Representative _____Date_____

Print Name_____

Personal Representative's Title *(e.g., Guardian, Executor of Estate, Health Care Power of Attorney)* _____

Initial all statements that apply:

_____ I authorize UPT to leave messages regarding my appointments on my home answering machine.

_____ I authorize UPT to discuss my appointments and my billing account with the following individuals:

Name:_____Relationship to patient: _____

Name:_____Relationship to patient: _____

For Facility Use Only: Complete this section if you are unable to obtain a signature.

1. If the patient or personal representative is unable to sign this Acknowledgement, or the Acknowledgement is not signed for any other reason, state the reason:

2. Describe the steps taken to obtain the patient's or personal representative's signature on the Acknowledgement:

Completed by:	**Signature of Facility Representative**	**Date**
_____	_____	_____

UNITED PHYSICAL THERAPY MEDICAL HISTORY FORM

Name_____

Occupation:_____

- Reason for visit _____
- Name of referring physician _____
- Name of other providers (chiropractors, physical therapists, physicians, etc) that you've seen for your current condition? _____

Past Medical History:

Have you ever had any of the following conditions? Check all that apply.

□High blood pressure	□Heart condition	□Stroke	□Osteoporosis
□Peripheral Neuropathy	□Seizures/epilepsy	□Vision problems	□Diabetes
□Hearing problems	□Fainting/dizziness	□Emphysema	□Asthma
□Cancer	□Thyroid problems	□Arthritis	□Lupus
□Frequent or severe headaches		□Bowel/bladder problems	

□Other:_____

Have you had any falls in the past year?	YES	NO	If so, about how many? _____
Do you have a history of fractures?	YES	NO	Where?_____
Do you have any metal implants?	YES	NO	Where?_____
Do you smoke?	YES	NO	How much per day?_____
Do you exercise regularly?	YES	NO	How often?_____
Do you have any known allergies?	YES	NO	Please list_____

Medications:

Please list any medications/supplements (prescribed or over-the-counter) that you are currently taking:

_____

_____

Surgeries: Please list all surgeries (include dates):_____

_____

Diagnostic Tests: Please check any tests or procedures that have been done for your **current** condition.

□X-rays	□MRI	□CT scan	□Bone scan
□EMG	□Blood work	□Bone density	□Ultrasound

Doctor(s) who ordered the Diagnostic Tests: _____

Current Condition

- What is the date when the problem started? _____
- Have you had similar symptoms before? _____
- Have you had previous treatment for this condition? _____

Does your pain limit any of the following activities:

□Lifting from the floor	□Sitting	□Head motion	□Shopping
□Lifting overhead	□Standing	□Twisting	□Doing dishes
□Reaching	□Walking	□Bending	□Housework
□Stairs	□Sleeping	□Squatting	□Yardwork

Please rate your pain level you are experiencing right now. 0= none, 10= severe

0 1 2 3 4 5 6 7 8 9 10

What is the highest pain level you had in the past week?

0 1 2 3 4 5 6 7 8 9 10

What is the lowest pain level you had in the past week?

0 1 2 3 4 5 6 7 8 9 10

Please list any important activities that you are unable to do or are having difficulty with as a result of your current problem. Please rate each of these problems on the 0-10 scale below.

0= Unable to perform the activity (cannot perform)
10= Ability to perform activity at the same level as before the injury or problem (no issues)

***Activity*_____**

0 1 2 3 4 5 6 7 8 9 10
(cannot perform) (No issues)

***Activity*_____**

0 1 2 3 4 5 6 7 8 9 10
(cannot perform) (No issues)

***Activity*_____**

0 1 2 3 4 5 6 7 8 9 10
(cannot perform) (No issues)

Signature: _____ Date:_____