



PhysioFit

Flexion of the Body & Extension of the Mind

NAME: _____
LAST FIRST MIDDLE

ADDRESS: _____
STREET CITY STATE ZIP

PHONE: HOME: () _____ WORK: () _____ CELL: () _____

EMAIL ADDRESS: _____

DATE OF BIRTH: _____

SOCIAL SECURITY #: _____

MARITAL STATUS: SINGLE MARRIED
 WIDOWED DIVORCED

REFERRING PHYSICIAN: _____

EMERGENCY CONTACT: NAME: _____ **RELATION:** _____ **PHONE:** _____

PRIMARY INSURANCE: _____

IS THIS INSURANCE POLICY IN: YOUR NAME YOUR SPOUSES NAME OTHER
SPOUSE'S DOB: _____

SECONDARY INSURANCE: _____

ARE YOU AWARE OF YOUR INSURANCE BENEFITS? YES NO

HAVE YOU RECEIVED PHYSICAL THERAPY FOR THIS PROBLEM? YES NO

HAVE YOU RECEIVED OTHER TREATMENT FOR THIS PROBLEM? YES NO

DATE OF YOUR NEXT DOCTOR'S APPOINTMENT? _____

WORK STATUS: CURRENTLY WORKING ON MATERNITY LEAVE NOT EMPLOYED OTHER

LOCATION/ TYPE OF WORK: _____

HOW MANY HOURS PER DAY ARE YOUR AT WORK? _____

DO YOU PRIMARILY SIT, STAND, WALK, OTHER? _____



Please read this form completely. By placing you initials on the appropriate line indicates you have read the sections and your signature at the bottom of the form indicates that you agree to this form in its entirety.

CONSENT FOR CARE AND TREATMENT

I, THE UNDERSIGNED, DO HEREBY AGREE AND GIVE MY CONSENT FOR PhysioFit and its employees to furnish physical therapy care and treatment considered necessary and proper in diagnosing and/or treating my physical condition.

_____ (Patient/Guardian Initials)

BENEFIT ASSIGNMENT/ RELEASE OF INFORMATION

I hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance, or any other health/auto insurance plans to PhysioFit. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary (including photocopies of medical records) to secure payments (See HIPPA/"PHI" Form). I hereby authorize any Office/Doctor whom I have seen in the past or am currently seeing to release any and all of my medical records and/or diagnostic imaging to PhysioFit Physical Therapy.

_____ (Patient/Guardian Initials)

My signature below indicates that I have read and agree to all sections of this form. Thank you for your cooperation.

Signature of Patient/Guardian _____

Date _____

PLEASE FILL OUT THIS FORM AS COMPLETELY AS POSSIBLE, AS IT WILL HELP BETTER ASSIST YOUR THERAPIST IN DEVELOPING A PLAN OF CARE FOR YOU. IF YOU HAVE ANY QUESTIONS PLEASE FEEL FREE TO ASK FOR ASSISTANCE. THIS INFORMATION IS CONFIDENTIAL.

Medical History (please circle all that apply): heart problems / hypertension / diabetes / hypoglycemia / cancer / seizures / thyroid dysfunction / hx of fractures / asthma / chronic bronchitis / lung disease / smoker / osteoarthritis / rheumatoid arthritis / hx of stroke / kidney problems / depression / preclampsia / DVT's / other: _____

Gynecological History (fill in blanks or circle answer for all that apply):

Number of: Pregnancies _____ Miscarriages: _____ Vaginal Deliveries: _____ C-Sections: _____

Number of episiotomies: _____ Number of vacuum/forceps assisted deliveries: _____

Did you experience tearing of need stitches? YES or NO

Birthdates and weights of each baby: _____

Any problems (physical or other) after previous deliveries? _____

Any history or currently have: feelings of pelvis heaviness / fibroids / cysts / endometriosis

Please list all prescriptions medications you are taking (including injections and skin patches):

Please list all over the counter medications you are taking: _____

Please list any surgeries or other conditions for which you have been hospitalized:

DATE	SURGERIES/HOSPITALIZATION	REASON
_____	_____	_____
_____	_____	_____
_____	_____	_____

CURRENT STATUS (Place an X by the statement that applies and answer related questions) :

_____ **I am currently pregnant.**

I am at _____ weeks gestation, with the due date of _____.

Have you had any concerns during this pregnancy? YES or NO

If yes, please specify: _____

Has your physician placed you on any restrictions? YES or NO

If yes, please specify: _____

Have you experienced any problems during previous pregnancies? YES or NO

If yes, please specify: _____

_____ **I have had my baby already.**

I am _____ weeks post-partum, having delivered on the date of: _____.

Type of delivery (circle all that apply): Vaginal / forceps / vacuum / episiotomy / perineal tear / C-Section

If C-Section, was it planned or did you labor prior to procedure? _____

If you had a perineal tear, do you know what grade tear? _____

Did you experience any problems during this pregnancy? YES or NO

If yes, please specify: _____

Are you experiencing problems at site of C-Section, episiotomy or perineal tear? YES or NO

If yes, please specify: _____

_____ **I recently experienced a miscarriage.**

Date of miscarriage: _____

Any other information : _____

BOWEL/ BLADDER SYMPTOMS (Please answer "yes" or "no". If "yes", please describe the problem)

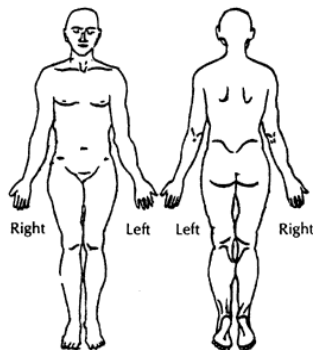
Are you experiencing any problems with urinating or leaking urine? _____

Are you experiencing any problems with bowel movements or leaking feces or gas? _____

CURRENT SYMPTOMS:

What brings you in for therapy today? _____

Do you have pain? YES or NO If Yes, please shade the area(s) of pain on the drawing below:



How would you describe your pain? (deep, sharp, stabbing, throbbing, dull, shooting?) _____

Are any of your normal activities limited by pain? YES or NO

If yes, please specify: _____

What makes your pain worse? _____

What makes your pain better? _____

Rate your pain on a scale from 0 to 10 (0 is no pain, 10 is worst imaginable pain)

Worst: _____ Best: _____ Average: _____

Is there any other information you would like us to know about regarding your symptoms? _____

Please tell us what you hope to achieve through therapy: _____

Fill out the following section ONLY if you have given birth in the last 12 weeks:

Answer the 3 questions by placing a X next to your response:

IN THE LAST 7 DAYS:

I have blamed myself unnecessarily when things went wrong:

_____ Yes, all the time

_____ Yes, most of the time

_____ No, not very often

_____ No, not at all

I have felt panicky or scared for no very good reason.

_____ Yes, all the time

_____ Yes, most of the time

_____ No, not very often

_____ No, not at all

I have been anxious or worried for no good reason.

_____ Yes, all the time

_____ Yes, most of the time

_____ No, not very often

_____ No, not at all

PhysioFit Patient Financial Policy

Patients Name: _____ Date of Birth: _____

Patient agrees to pay for all services due in full at time services are provided by our office.

Patient Financial Class Policies:

You are required to present a valid insurance card and identification card at every visit as needed throughout your care.

Commercial Insurance Carriers: We bill most insurance carriers for you if proper paperwork is provided to us. Any outstanding balances, co-payments and deductibles are due prior to checking in for your appointments. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated. If your insurance company requires preauthorization for physical therapy services it is your responsibility to get preauthorization before treatments begin. If an insurance carrier has not paid within 60 days of billing, fees are due and payable in full from you. Please note that at this time, PhysioFit is considered “out of network” with Blue Cross/ Blue Shield and United Healthcare, which means that you will be responsible for your out of network copayment and deductible which are usually higher than your in network responsibilities.

Medicare: Our office is a Medicare participating provider and we will bill Medicare for you. We will also bill your secondary insurance for you. Any balance not paid by Medicare and your secondary insurance will be your responsibility. Medicare allows \$1,880.00 per calendar year for outpatient physical therapy and speech language therapy combined. Outpatient therapy settings include: private practices, skilled nursing facilities (SNF’s), home health agencies, outpatient rehabilitation facilities, comprehensive outpatient rehabilitation facilities, hospital outpatient departments. If your therapy services go over the \$1,880.00 therapy cap, your therapist or doctor can ask for an exception, should they determine that the services continue to be medically necessary. Even if your therapist or doctor asks for an exception, this is not a guarantee that you will not have to pay for costs above the \$1,880.00 therapy cap amounts. If Medicare decides, at any time (even after your therapy services have been paid for), that your therapist or doctor did not show enough proof that your therapy services were medically necessary, you may have to pay for the total cost of the services above the \$1,880 therapy cap amount.

Worker’s Compensation: If your visit is work- related we will need the case number and carrier name prior to your visit in order To correctly bill your workers compensation insurance carrier.

Auto-Mobile Accidents: If your visit is auto-accident related we will need the case number and carrier name prior to your visit in order to bill the car insurance company. If at any time during your visits at PhysioFit you exceed your physical therapy limit set by the car insurance carrier you will be responsible for the remaining balance. At this time, we can bill your primary health insurance if you would like, but if they do not pay, the balance will be the patient’s responsibility. Our office does not accept Letters of Protection for any services that are rendered once your PIP benefits have been exhausted, these services must be paid at time of visit.

Methods of payment:

Our office accepts the following payment methods:

Cash, Personal Check, Credit Cards and Patient Financing options for those patients who are credit worthy.

For **returned checks**, we assess a \$25.00 NSF charge, and report to the local district attorney’s office checks that are not paid within 2 weeks of being returned to our office.

If not paid according to terms the patient understands that our office reports to an outside collection agency. In the event that your account is turned over for collections, patient agrees to pay all additional fees accessed in the collection of debt. These fees include collection agency fees and attorney fees.

The patient is ultimately responsible for all fees for services. I have read, understand and agreed to the above financial policy for payments of professional fees.

Patient Name: _____ **Date:** _____

Patient Signature: _____ **Date:** _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

As part of my health care, PhysioFit (The Company) creates and stores information about me. This includes records concerning my health history, symptoms, examinations, test results and plans for future care.

I understand that this information serves as a basis for my continuing care. I understand that this information is used as a means of communicating among The Company's personnel, and with medical personnel outside of this practice. I understand that this information serves as a source of information for applying my diagnosis and surgical information to my bill. I understand that this information is a way for third party insurance companies to assure that a service we bill for was actually performed.

I understand that this information can be used as a tool to assess the quality of care provided to patients. I have been provided an opportunity to review the Notice of Privacy Practices for The Company that provides a more complete review of information uses and disclosures. I understand that I have the right to review this Notice of Privacy Practices before signing this consent.

I understand that The Company may change its Notice of Privacy Practices at any time and that a current copy will be available for my inspection during regular business hours of each medical office.

I understand that I have the right to request restrictions as to how my information may be disclosed to carry out treatment, payment or other healthcare operations and that The Company is not required to agree to the restrictions requested. The procedure to request restrictions on information use and disclosure is contained in the Notice of Privacy Practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices of PhysioFit and agree to the liability limitations explained therein.

Signature of Patient or legal representative

Date

Relationship to the Patient

Printed Name of Patient