General Patient Information

Name of person completing this form _____

How did you hear about us? _____

Was this the first time you heard of us? _____ If no, where? _____

Discipline requested: physical therapy occupational therapy speech therapy

Patient Information

Patient name _____ DOB _____

Gender _____ Marital status _____

Address _____

Home phone _____ Cell phone _____

Email address _____

Patient employer/school _____ Phone _____

Emergency Contact

Name _____ Relationship _____

Home phone _____ Cell phone _____

Referring Physician

Name _____

Address _____

Phone _____ Fax _____

Primary Care Physician (skip if matches above)

Name _____

Address _____

Phone _____ Fax _____

Accident Information

Is this injury due to an accident? _____ If so, what type (auto, work, etc.)? _____

Date of injury _____ Have you made a report of your accident? _____

Attorney name and contact information _____

Specialty Physical Therapy

Condition Information

Patient name _____

Reason for visit _____

When did your symptoms appear? _____ Is this condition getting worse? _____

Rate severity of pain on a scale of 1 (least pain) - 10 (severe pain) _____

Are any of the following activities or movements painful to perform?

___ sitting ___ standing ___ walking ___ bending ___ lying down _____

How would you describe your pain?

___ sharp ___ burning ___ throbbing ___ numbness ___ cramps ___ aching

___ dull ___ stiffness ___ shooting ___ swelling ___ tingling _____

How often do you have this pain? _____ Is it constant or intermittent? _____

Does it interfere with your work, sleep, daily routine, and/or recreational activities? _____

If so, how? _____

Rate current functional status with self-care and home management activities (1-10): _____

How does this compare to your functional status with self-care and home management activities before this condition or injury? _____

Have you experienced any of the following?

_____ changes in bowel/bladder _____ non-healing sores/wounds _____ fatigue

_____ unexplained weight loss _____ referred or radiating pain _____ fever/sweats

_____ pain worse at rest vs activity _____ unexplained lower or upper extremity weakness

Are you currently pregnant? _____ If so, what is your due date? _____

Do you live alone? _____ If no, with whom do you live? _____

What type of home (one-story, two-story, apartment, etc.)? _____

Are there stairs in the home or to get into home? _____ If yes, how many? _____

Are you currently working? _____ What is your occupation? _____

Do you smoke? _____ If yes, how many packs per day? _____ For how long? _____

Do you drink alcohol? _____ If yes, how many drinks per day? _____ For how long? _____

Do you exercise? _____ If yes, how many times per week? _____ For how long? _____

Specialty Physical Therapy

History Information

Patient name _____

Have you received any of the following treatment(s) for your condition/injury?

___ medication ___ surgery ___ physical therapy ___ chiropractic _____

If yes, please describe: _____

Names of other doctors who have treated you for your condition: _____

_____

Have you had any diagnostic testing (X-rays, MRIs, cat scans, bone scans, etc.)? _____

If so, what kinds? _____

If you have had testing, please provide dates: _____

Have you been diagnosed with any of the following conditions?

___ osteoporosis	___ have a pacemaker	___ kidney disease
___ cancer	___ hearing or visual impairment	___ vertigo
___ diabetes	___ thyroid problem	___ history of falls
___ arthritis	___ depression	___ high cholesterol
___ high blood pressure	___ seizures	___ contagious disease
___ circulatory problems	___ heart problems	___ stroke

Please list any other injuries or diagnoses not listed above: _____

Please list all past injuries and/or surgeries you have had with dates: _____

_____

Are you currently taking over-the-counter medication, vitamins, or supplements? _____
If yes, please list: _____

Are you currently taking prescribed medication? _____ If yes, please list: _____

_____

Have you received or are you planning to receive home health services of any kind? _____

Is there anything you would like us to know about you? _____

_____

_____

_____

Specialty Physical Therapy

CONSENT TO RECEIVE AUTOMATED TEXTS AND PRERECORDED CALLS

I, the undersigned patient or his legal representative and/or guardian ("Undersigned"), hereby provide express consent to receive autodialed, artificial voice, and/or prerecorded calls and automated text messages from Specialty Physical Therapy, its affiliates, its partners, and/or its employees (collectively, "Provider") at any and all phone number(s) I provide. I understand that messaging, data, and other rates may apply and that I may revoke this consent at any time.

AUTHORIZATION TO OBTAIN AND RELEASE MEDICAL RECORDS

Undersigned hereby authorizes Provider to obtain and release the patient's Protected Health Information (PHI) including but not limited to his health history, physical exams, lab reports, progress notes, X-ray and similar reports, substance abuse (including alcohol/drug abuse and dependance) information, mental health information (including psychotherapy notes), and HIV test results and other related information (including AIDS-related testing and conditions).

Undersigned understands that this authorization will expire three hundred and sixty-five (365) days from the date he/she signed this form and that the patient or Undersigned may revoke this authorization at any time by notifying the providing organization in writing. The revocation will be effective on the date notice was received by Provider except to the extent that action has already been taken upon this authorization. The revocation will not apply to information that has already been released in response to this authorization.

Undersigned understands that the revocation will not apply to the patient's insurance company when the law provides the patient's insurer with the right to contest a claim under the patient's policy. Undersigned understands there may be charges for the copying and release of information and personally accepts financial responsibility. Undersigned also understands that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected.

PRIVACY NOTICE

By signing below, Undersigned acknowledges that the patient has received a copy of this practice's Notice of Privacy Policies, which details how the patient's information may be used and disclosed as permitted under federal and state law, and that the patient understands his rights as a patient regarding his personal health information.

TREATMENT COMMITMENT

We at Specialty Physical Therapy care very much about each person we treat. We request of you, our patient, a commitment to help us deliver exceptional care. You play a large role in your health by the actions you choose to take. Listed are some of your responsibilities as a patient at Specialty Physical Therapy:

1. attending, on time, all scheduled appointments
2. informing your therapist(s) of your progress at each visit
3. complying with your treatment plan developed by your therapist
4. asking questions when you do not understand any directions given to you by our staff
5. notifying your therapist of your next doctor's appointment in advance of the appointment

CANCELLATION AND NO-SHOW POLICY

We strive to provide our patients with the utmost professionalism and excellence of service. The patient's adherence to the recommended number of treatments is a vital component

of his progress; therefore, we have certain rules that need to be followed to ensure the most optimum results. By signing below, Undersigned agrees to pay a twenty-five dollar ($25) fee for each of the patient's no-shows or cancellations without twenty-four (24) hours of notice. (These fees are not charged to Medicaid patients, their legal representatives, and/or their guardians.) After the second no-show or third cancelled appointment, we reserve the right to remove all of the patient's future appointments from the schedule and add the patient to our "same day appointment only" list. In instances of repeated non-compliance with the patient's scheduled visits, we also reserve the right to discontinue care and to inform the patient's physician of the fact that the patient's service has been discontinued due to non-compliance with the prescribed rehabilitation order. Undersigned understands that Provider's records will be used exclusively to determine if a cancellation/no-show fee is owed. We appreciate you greatly as our patient and strive to accomplish wonderful results and success for you.

AUTHORIZATION TO CHARGE CREDIT CARDS

Undersigned hereby authorizes Provider to charge any and all credit card(s) and/or bank account(s) supplied to Provider by either patient or Undersigned. Undersigned understands that he may revoke this authorization at any time and agrees not to dispute these charges so long as they are made in accordance with this agreement.

FINANCIAL POLICY

If the patient has medical insurance, we at Specialty Physical Therapy are happy to assist Undersigned in receiving the patient's maximum allowable benefits. To achieve this goal, we need Undersigned to understand our payment policy.

Copays are due at the time services are rendered unless other acceptable arrangements have been approved in advance, in writing, by our practice's Office Manager. All written correspondence must be signed and dated by the Office Manager to be considered valid. Each check that is not honored by our practice's bank and each charge returned NSF is subject to a $45 fee. This fee may be charged automatically as described above. Balances not paid when due may be subject to additional collection and legal fees as well as interest charges of up to six percent (6%) per year. We will try our best to be accommodating to the patient in the process of seeking reimbursement from his insurance carrier.

If the patient participates with our in-network groups, we will bill his insurance company and accept assignment of benefits. We will gladly discuss the patient's proposed treatment with the patient and/or Undersigned and answer any questions we can relating to your insurance.

As our patient, please be aware of the following:

1. Your insurance policy is a contract between you, your employer (if applicable), and the insurance company.

2. Our fees are generally considered by most companies to fall within the acceptable range and, therefore, are covered up to the maximum allowance determined by each carrier.

3. Not all services and diagnosis codes are covered in all insurance contracts.

4. Verification of your insurance benefits is not a guarantee that payment will be made.

In cases involving auto claims and Worker's Compensation, we will only accept payment directly from the patient or from his insurance company and may arrange to accept payments from attorneys on a case by case basis. If the patient has instructed his insurance company to send

payment to his attorney, the patient will be billed and held solely responsible and accountable for said bill. We will accept settlements on auto accounts only after prior approval and a letter of protection is on file. We must emphasize that, as a medical provider, our relationship is with the patient, not with his insurance company.

While the filing of an insurance claim is a courtesy that we extend to our patients, all charges are Undersigned's responsibility from the date the services were rendered. We realize that temporary financial problems may affect timely payment of the patient's account. If such problems do arise, please contact us promptly for assistance in the management of the patient's account. If Undersigned has any questions about the above policy or any uncertainty regarding the patient's insurance coverage, please don't hesitate to ask us. We are here to help!

ASSIGNMENT OF MEDICAL BENEFITS, PAYMENT RESPONSIBILITY, AND MORE

Undersigned hereby authorizes Provider to render to the patient physical therapy, occupational therapy, speech therapy, and/or other related services (collectively, "Therapy Services") that Provider or the patient's treating physician determines may be necessary or advisable. Undersigned agrees to cooperate with all reasonable requests by Provider in connection with Provider's rendition of Therapy Services.

Undersigned hereby certifies that all information provided to Provider, including any information in connection with applying for a payment under Title XVIII of the Social Security Act, is true and accurate in all respects. Undersigned accepts liability for false and/or misleading information. Undersigned acknowledges that Provider has disclosed that no physician maintains an ownership interest in Specialty Physical Therapy. Undersigned understands that the patient has a choice of rehabilitation service providers. Undersigned warrants and represents to Provider that the patient is not a member of, or covered by, a health maintenance organization or similar arrangement. The patient shall be liable to Provider for all services rendered by Provider in the event the patient is covered by a health maintenance organization or similar arrangement.

Undersigned hereby authorizes Provider to disclose any information furnished to Provider or obtained by Provider in connection with the patient's treatment (including information concerning a related Medicare claim), to any physician, governmental agency (including the Social Security Administration or any of its intermediaries or carriers), insurance company, or health care facility.

Undersigned hereby assigns to Provider all Medicare benefits and Medicaid benefits to which the patient may be entitled for any Therapy Services rendered by Provider. Undersigned hereby authorizes and directs Provider to apply and file for all such benefits on behalf of the patient. In the event the patient is covered by both Medicare and Medicaid, the patient's Medicare deductible and any applicable Medicare copayment will be covered by Medicaid. Undersigned acknowledges that Provider has disclosed that Provider is a supplemental Medicaid provider and that Provider is paid directly by Medicaid. In addition, Undersigned authorizes contact with the patient's family members for medical claim management purposes.

Undersigned hereby assigns to Provider all of the patient's private medical insurance benefits (primary and secondary, including med. Gap providers) or other benefits to which the patient may be entitled for any Therapy Services rendered by Provider. Undersigned hereby authorizes and directs Provider to apply and file for all such benefits on behalf of the patient.

Undersigned hereby authorizes Provider to deposit checks received on the patient's account when made out to the patient or Undersigned or signed over by the patient or Undersigned when the insurance company pays against services provided.

Undersigned agrees to execute any documents and perform any acts that Provider may reasonably request. If in existence, the patient's legal representative and/or guardian warrants and represents that attached hereto are originals or certified copies of any applicable powers of attorney, health care surrogate forms, or court orders appointing the legal guardian of Patient. Undersigned agrees that the provisions hereof shall continue in full force and effect until Provider has received written notice of termination signed by Undersigned; however, the provisions of paragraphs 2, 4, 5, and 6 shall survive any such termination.

Undersigned authorizes Provider to take and use success stories, photographs, video, and/or digital images of the patient for use in marketing and/or educational materials. These materials may include printed or electronic publications, websites, and/or other electronic communications. Undersigned further agrees that names and identities may be revealed in descriptive text or commentary in connection with the image(s). Undersigned authorizes the use of these images without compensation. All negatives, prints, and digital reproductions shall be the property of Specialty Physical Therapy.

By signing this contract below, Undersigned agrees he has read and understands all the terms, conditions, and other items outlined above. Undersigned attests that he was given sufficient time to review this document (four pages total) and that any and all questions were answered satisfactorily. If Undersigned does not understand the contract and/or its terms, Undersigned should seek the advice of an attorney and/or other legal professional before signing. A copy of this document shall be considered as effective and valid as the original.

_____	_____
Undersigned's Printed Name	Office Manager's Signature
_____	_____
Undersigned's Signature	Treating Therapist's Signature
_____	_____
Date	Witness's Signature (optional)

Specialty Physical Therapy