



PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____
Date of Birth: ___/___/___ Age: _____ Gender: ___ Male ___ Female Marital Status: _____
Street Address: _____
City: _____ State: _____ Zip Code : _____
Home Phone: _____ Cell Phone: _____ email address: _____

Appointment Reminder Method

Name of Cellular Provider is required for text reminders _____ Text _____ Email _____ or Both

Emergency Contact

Name: _____ Phone Number: _____ Relationship to Patient: _____

Responsible Party

Name : _____ Phone number: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____
Employer: _____
Address: _____ City: _____ State: _____ Zip: _____

Insurance Information:

WE DO NOT FILE SECONDARY ON ANY COMMERCIAL INSURANCE PLANS.

WE ONLY FILE SECONDARY ON TRADITIONAL MEDICARE PLANS AND ONLY IF TRADITIONAL MEDICARE PLAN IS THE PRIMARY INSURANCE. WE DO NOT FILE MEDICARE AS SECONDARY AT ANY TIME!

Primary Insurance: _____ Member ID # _____ phone: _____
Secondary Insurance: _____ Member ID # _____ Phone: _____
How did you hear about us: _____ MD ___ Family/Friend _____ Internet Search _____ Insurance Company _____ Other
Whom May we thank for your referral: _____

Case Information

Injury/Surgical Type: _____ Injury/Surgical Date: _____
Referring Physician: _____ Phone Number: _____
Date of Last Appointment: _____ Date of next Appointment: _____
Primary Care Physician (if different) _____ Phone Number: _____
Was this Motor Vehicle Accident: _____ Yes _____ No If Yes, what state did the accident occur in? _____
Is this a Worker's Compensation Case _____ Yes _____ No
If yes, Case Workers Name: _____ Phone: _____ Case Number: _____

Signature: _____ Date: _____

PATIENT HISTORY AND PHYSICAL

NAME: _____ Height: _____ Weight: _____ Age: _____ Today's Date: _____

Medical & Surgical History:

- Arthritis: TYPE _____ Broken Bone/Fracture: BONE _____ WHEN _____
- Cancer: TYPE _____ WHEN _____ Circulation/Vascular Problems Depression
- Dizziness/Fainting/Vertigo Diabetes: TYPE _____ Gastrointestinal Problems Hearing Problems
- Hernia High Blood Pressure Infectious Disease: TYPE _____ WHEN _____
- Joint Replacement: TYPE _____; WHEN _____ Kidney Problems Lung Problems Memory Problems
- Osteopenia Osteoporosis Pacemaker Pregnancy: WHEN _____ Stroke Thyroid Problems
- Other Medical Diagnoses: _____

Please list your entire **SURGICAL** history on the lines below, including type & approximate date:

Please list any relevant family medical history: _____

Current Medications: (Prescription, nonprescription and Supplements) *Please include frequency and dosage*

Allergies: Do you have a latex allergy? Yes No

List all other allergies: _____

Clinical Tests/Interventions Performed for this Condition:

- Angiogram Bone Scan CT Scan Electrocardiogram MRI NCV (nerve conduction test) Stress Test X-Rays
- Injection(s): TYPE _____ WHEN _____ (i.e cortisone, epidural, etc)

Personal History:

What are you goals for physical therapy? _____

Current Employment: _____ Average Blood Pressure: _____ Are You: Right handed Left handed

Who do you live with? Alone Spouse Child Other Relative Other _____

Where do you live? Private Housing/Apartment Assisted Living Other _____

Living Space: One level Multi-level Stairs necessary: NUMBER INTO/OUT OF HOUSE _____ NUMBER IN HOUSE _____

Do you use: Cane Walker Manual Wheelchair Motorized Wheelchair Other _____

Tobacco Use? Never Past Current; if current type/how much? _____

Alcohol use: Never Past Current; if current type/how much? _____

Do you exercise regularly: Yes No If yes, how often and what types? _____

Rate your health: Excellent Very Good Fair Poor

PLEASE CONTINUE ON BACK TO COMPLETE THE REST OF THE FORM

Current Condition (reason for today's visit):

What happened? _____
When did this problem begin? _____
Have you ever had this problem before? Yes No if yes, when? _____
How long did the problem last? _____ Did the problem get better? _____
What makes the problem better? _____
What makes the problem worse? _____
How are you taking care of the problem now? _____
What activities are you not able to do now because of the problem? _____
Are you seeing anyone else for the problem? _____

Using the diagram on the right, please mark your painful areas:

Please rate the level of your pain:

Which of these words describes your pain?

(circle all that apply)

Aching Burning Cramping Dull Numbness
Radiating Sharp Sore Stiff Tight Tingling

Score your pain levels, using the scale below:

(0 = no pain; 10 = emergency room pain)

At best: 0 1 2 3 4 5 6 7 8 9 10

At worst: 0 1 2 3 4 5 6 7 8 9 10

At present: 0 1 2 3 4 5 6 7 8 9 10

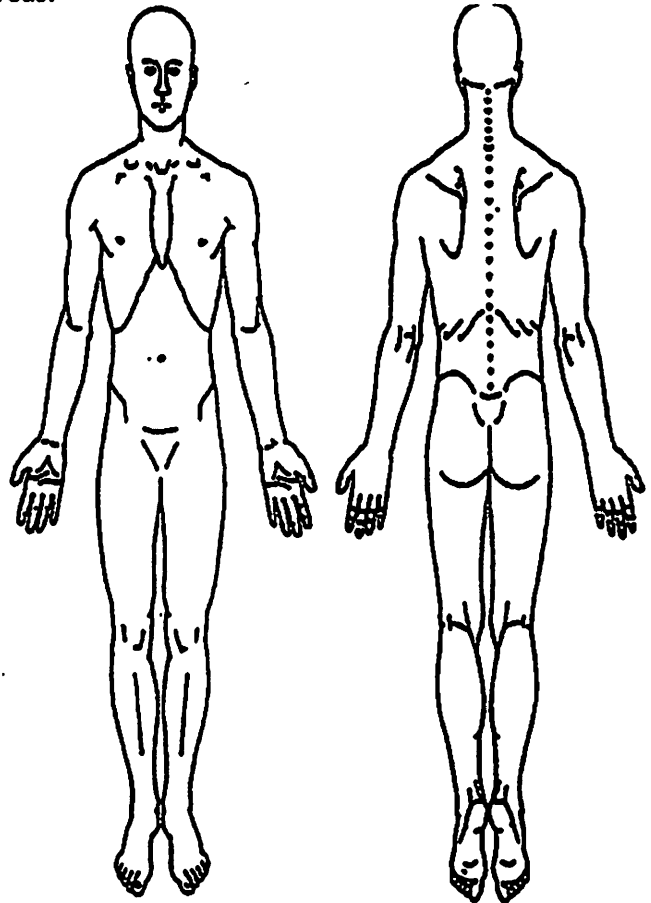
How frequently are you having pain?

_____ Intermittently (<26%)

_____ Occasionally (25-50%)

_____ Frequently (51-75%)

_____ Constantly (>75%)



PATIENT SIGNATURE

DATE

NORTH FULTON



**Physical
Therapy
& Sports
Medicine**

Patient Name: _____ Today's Date: _____

North Fulton Physical Therapy is dedicated to providing the best possible care for you in a warm, comfortable environment. All services are provided by a licensed Physical Therapist.

By signing below, I acknowledge and consent to the following, where applicable:

1. **MEDICAL CONSENT:** I authorize North Fulton Physical Therapy to perform physical therapy assessment and treatment which will be discussed with my therapist.
2. **PAYMENT FOR SERVICES:** I understand that payment is expected at the time of service and I am fully responsible for all fees that are not covered by my insurance except those prohibited by the insurance carrier. Insurance will be filed for services rendered as directed by me. Co-pays and co-insurance are expected at the time of service.
3. **MEDICAL INSURANCE BENEFITS:** North Fulton Physical Therapy will verify my insurance coverage prior to service and filing claims. Based on this information, North Fulton Physical Therapy will estimate the portion of charges for which I should be responsible, taking into consideration coordination of benefits should I have coverage under multiple insurance policies. North Fulton Physical Therapy will only file secondary insurance if primary insurance is a traditional Medicare policy.
4. **MEDICARE AUTHORIZATION:** I certify that the information given in applying for payment under TITLE XVII of the Social Security Act is correct and requests payment of authorized benefits to be made on my behalf. I authorize North Fulton Physical Therapy to release to Medicare Bureau, Health Care Financing Administration or its intermediaries or its carriers, any information needed for Medicare claims. Including medical information for the purpose of processing a claim for Medicare benefits. I also authorize the release of medical and related information about my treatment to the utilization and quality control peer review organization responsible for reviewing the medical care furnished.
5. **SELF PAY DISCOUNT:** A discount is available to those who pay in full at the time of service and do not require North Fulton Physical Therapy to file claims with health insurance. If I choose for North Fulton Physical Therapy not to file claims or take any insurance information, I may file with my health insurance on my own. In this case North Fulton Physical Therapy will provide proper receipts and documentation to be submitted.
6. **MEDICAL RECORDS RELEASE:** I authorize North Fulton Physical Therapy to release my medical records (including any information furnished to North Fulton Physical Therapy or obtained by North Fulton Physical Therapy in connection with my treatment) to any referring physician, insurance company health care facility or government agency requesting such information. Authorization is also given to release records to insurance carriers for the purpose of payment of claims including worker's compensation claims to both carrier and employer.

I authorize the release of any medical information to the following person(s)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

7. **SCHEDULING POLICY:** North Fulton Physical Therapy does not offer standing schedule appointments, each appointment is to be scheduled with the front office staff. North Fulton Physical Therapy tries to run on time with our appointments, if you are late more than 15 minutes for your appointment North Fulton Physical Therapy reserves the right to reschedule that appointment.
8. **CANCELLATION POLICY:** North Fulton Physical Therapy requires that I give **24-hour prior notice for canceling** or rescheduling of appointments. There is a **\$30.00** no show or late cancellation fee, insurance does not cover this fee.
9. **SELF-REFERRED/DIRECT ACCESS:** I understand that a physical therapist diagnosis is not a medical diagnosis by a Self-Referred/Direct Access allows for treatment for 21 days or **8 visits** from the initiation of a physical Therapy plan of intervention.
I understand that as a self-referred patient I am unable to receive dry needling without my Physical Therapist consulting with my Physician.
10. **ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICE NOTICE:** I acknowledge that I have been given or offered a copy of the Notice of Privacy Practices and am providing consent for the use of my protected health information in the manner described in the Notice of Privacy Practices.

11. VISIT LIMITATION POLICY

North Fulton Physical Therapy will review your insurance limitations. Most policies have a visit limitation for outpatient physical therapy. We will try to ascertain if any of your visits have been used previous to your appointment at North Fulton Physical Therapy. You are responsible in keeping up with your visit count as insurance companies can not always give an accurate account of visits used. Chiropractic care is also sometimes applied towards Physical Therapy limitations. If you have you have used any visits prior to coming to North Fulton Physical Therapy, we will need this visit count.

Have you had any Physical Therapy, Occupational Therapy, Speech Therapy, Cardiac Rehab or any Chiropractic care this year.

Yes _____ or No _____ If yes, how many visits have been used? _____

Patient Name: _____ **Date of Birth:** _____

Signature: _____ **Today's Date:** _____

If patient is a minor, or uncappable to sign for one's self then this form should be signed by Parent or Guardian

Printed Name of Parent or Guardian: _____