Demographic and cancellation policy Information

Patient Name: _____ Are you a minor: _____

Date of Birth: ___/___/___ Social Security#: ___/___/___ Gender: ___ Male or Female ____

Marital Status: _ Single _ Married _Widowed _Divorced

E-mail address: _____ Physician: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Employer Name/Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Updated No Show/ Cancellation Policy

Please Read It Carefully

We understand that emergencies and other scheduling conflict arise and are sometimes unavoidable, however, **24-hour** notice allows us to fill other patients scheduling needs and keeps the clinic at an efficient level.

Due to excessive cancelations we have been left no choice but to update our cancellation fee and strictly enforce our policy effective January 1,2020. The updated cancellation fee is **$60** if an appointment is cancelled within **24-hours**. Payment will be due at your next scheduled appointment.

Due to recent growth your knowledgeable therapist is in high demand. They are working hard to improve your health status and failure to come interrupts the plan of care they have carefully created for you.

X_____ X _____

Signature of Patient or Responsible Party Date

Medical History Form

Patient Name: _____ Date: _____

Information about current problem:

1. Is this injury related to? __Work __Car Accident __Other Liability/potential Lawsuit __ Not Applicable
2. Do you have Primary Care Physician/Family Doctor __ Yes __NO
   If YES, please provide a date of last appointment _____

mark one box for each item	NO	YES Under a year	YES, Over a year	mark one box for each item	NO	YES, under a year	YES Over a year
Heart Condition				Sexual dysfunction			
High Blood Pressure				Bladder/bowel problems			
Circulation/vascular problems				Seizures			
Blood Cloth/DVT				Head injury			
Stroke				Obesity			
Chest Pain				Fever/nausea			
Kidney Condition				Groin Numbness			
Diabetes				Osteoporosis			
Smoking				Arthritis			
Breathing Difficulties/Asthma				Fractures			
Cancer				Infection			
Difficulty swallowing				Chronic pain/fibro/headaches			
Metal implants				Psychological condition			
Pacemaker				Dizziness/Faintness			
Peripheral Neuropathy				Ringing in ears			
Unexplained weight loss				Allergy to latex			
Double vision				Other allergy			
Night sweats/night pain				Are you pregnant?			

Condition	NO	YES	If YES, please specify
Infection disease			
Neurologic condition (MS/Parkinson's)			
Skin Disease			
Spinal Cord Injury			
Degenerative Joint Disease			

Notice & Consent to Treat

Patient Name: _____ Location: _____Date: _____

Notice of Privacy Practices

Acknowledgement of Receipt

By signing this form, I acknowledge that I have been offered a copy for review of AxisPro Physical Therapy's Notice of Privacy Practices which is available in the clinic as well as on our website. This Notice of Privacy Practices provides information how we may use and disclose your protected medical information.

X_____ X_____
Signature of Patient or Responsible Party Date

Consent to treat & Authorization to release information, Assignment of Benefits, Financial responsibility

I hereby authorize AxisPro Physical Therapy, through its appropriate personnel, to perform the evaluation and treatment procedures that are deemed necessary by my physician and therapist in the treatment of my condition. I further authorize AxisPro Physical Therapy to furnish the appropriate agencies, for the purpose of billing, any information acquired during the course of my treatment and to send me notices and reminders of my appointments via text messages or email. I acknowledge that AxisPro Physical Therapy is released from all legal liability that may arise from release of my medical record. I agree to assign my therapy benefits to AxisPro Physical Therapy for the services in which I receive and authorize my insurance carrier to make payments to AxisPro on my behalf. It is my responsibility to inform the facility of changes to my insurance and policy as well as name, address and phone changes. I understand that I am responsible for payment of my account and the facility. I hereby do guarantee payment in full on my account with AxisPro Physical Therapy, LLC for treatments and services rendered. AxisPro Physical Therapy does not take responsibility for negotiating settlements of disputed claims. I understand that all co-payments, deductible, and/or coinsurance is to be paid at time services are rendered. All balances that accrue after the initial insurance payment that is received, is due upon receipt. If the account be referred to an attorney for collections, the undersigned agrees to pay all attorney's fees, court fees, legal and lawful collections costs in addition to all other sums due.

AxisPro Physical Therapy reserves the right to seek reimbursement from and all your insurers regardless if weather you provide us with their contact information, unless you instruct us to bill us directly. All records released require an administrative and copying fee paid to AxisPro before they are release, regardless of requestor. AxisPro Physical Therapy is HIPAA compliant with regard to information sharing polices.

By signing this document, I acknowledge that I have read, understand and agree that the information contained in this document including insurance benefits and any information I have presented to verify my own identity including my state issued driver's license, state issued photo identification card or my passport, and if applicable any information used to verify the identity of a minor beneficiary is current, correct and complete to the best of my knowledge. I agree to the financial terms stated above.

X_____ X_____
Signature of Patient or Responsible Party Date