PHYSICAL THERAPY PATIENT DATA SHEET

Patient Name: ____ Gender: M ____ F ____

Marital Status: Married ____ Single ____ Divorced ____ Widowed ____

Date of Birth: _____________________ Age: _______ Height: ___________ Weight: ________

Address: ____

Phone Numbers: Home: ____________________________ Cell: __________________________

May we send text messages for appointment reminders to the cell # above? Yes ___ No ___

May we send emails for appointment reminders/other communication? Yes ____ No ____

Email address: ____

Referring Physician: ____

Did you have an accident? Auto: _____ Work: ______ Date of Injury: ___________________

Are you currently receiving or have received (in last 90 days) any other
Physical Therapy Services? Yes _____ No _____

Occupation: ____

Employer/Address: ____

Primary Insurance: ____

Policy Holder's Name: ____

Policy Holder's Date of Birth: __________________ Policy #: ___________________________

Secondary Insurance: ____

Policy Holder's Name: ____

Policy Holder's Date of Birth: __________________ Policy #: ___________________________

Please read and Initial all of the statements below signifying your agreement/understanding:

CONSENT FOR TREATMENT: I understand that a full evaluation is necessary to assess my condition and determine an appropriate treatment plan. I will be asked to perform various movements and activities and services that may include close bodily contact, touch, etc. during treatment. I understand that PT may not help my condition and that there is a possibility it can aggravate my symptoms. I will inform my therapist as soon as possible if that happens. I give my consent for treatment. Initials: ______

TREATMENT OF MINORS: As parent/guardian of a minor receiving treatment, I do hereby agree and understand that I have been advised to remain on the premises during the evaluation. I will need to be present for subsequent treatment if asked to do so by staff. Initials: ______

AUTHORIZATION OF PAYMENT: I hereby assign all benefits directly to SSJPT. I authorize all release of any medical records to other health care providers as needed to facilitate treatment and to other third parties as necessary to process medical claims as otherwise permitted or required in the Notice of Privacy Practices. Initials: ______

FINANCIAL POLICY: I understand that I am responsible for all physical therapy charges provided to me, including all deductibles, coinsurance, and the balance remaining after payments of insurance benefits have been exhausted. I understand that my payment portion is collected at the time services are rendered. I understand that benefits quoted to me are only an estimate and SSJPT is not responsible for inaccurate information received from my insurance company. It is my responsibility to know and understand my health plan. I will notify SSJPT of any insurance changes during my care. If other payment arrangements must be made, I will discuss with the front office personnel. Initials: ______

CANCELLATION POLICY: We request 24-hour notice if you need to cancel your appointment, but we understand that sometimes unforeseen situations can arise. Please contact us ASAP to reschedule. However, we reserve the right to charge a $50 fee for a "No Show". If this becomes a problem (3 or more no shows), we reserve the right to terminate our relationship with you. Initials: ______

DIRECT ACCESS/PHYSICIAN REFERRAL: Nevada is a direct access state and patients can seek physical therapy care without a doctor's prescription. However, some insurances require a signed PT prescription from a physician. It is my responsibility to know if my health insurance requires a referral order.

Initials: ______

NOTICY OF PRIVACY PRACTICES:

I acknowledge receipt of Notice of Privacy Practices. Initials: ______

I certify that all the information provided is correct.

Patient/Guardian Signature: ____ Date: _________________

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