Patient Information

First Name (Legal): _____ MI: _____ Last: _____ DOB: ____/____/_____

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

Home Phone: _____ Cell Phone: _____ Appt. Text Reminders? Y | N

Email Address: _____ SSN: _____ (required)

Marital Status (circle): Single | Married | Divorced | Widowed Spouse/Partner's Name: _____

Work Status (circle): Student | Employed | Retired | N/A Are you Right or Left-Handed (circle)? R | L

Occupation: _____ Employer: _____

Guarantor Information

(The party listed below agrees to take financial responsibility for all account balances if the patient is under 18 y.o. or has a Healthcare POA.)

☐ Please check this box if *the patient is the guarantor and is over the age of 18*.

Guarantor Name: _____ Relationship to Patient: _____

DOB: _____/_____/_____ SSN: _____(required) Phone #: _____

Address (if different from above): _____ City: _____ State: _____ Zip:_____

Billing Information

☐ Please check this box if *the patient is the primary holder of the health insurance policy.*

Primary Insurance Co.: _____ Secondary Insurance Co.: _____

Policy Holder's Name: _____ Policy Holder's Name: _____

DOB: ____/____/_____ Relationship: _____ DOB: ____/____/_____ Relationship: _____

Appointment Policy:

1. Please arrive at, or just before (5 minutes early), your appointment time. Should you arrive significantly earlier than your scheduled appointment time, you may be asked to wait in the lobby until closer to the time of your appointment.
2. If you arrive 15+ minutes late for your appointment without notifying us prior, we reserve the right to ask you to reschedule your appointment to another day or we may adjust your treatment plan to accommodate our schedule and the other patients that have arrived on time.
3. Should you need to cancel, you may call up until the time of your scheduled appointment. If you are a "no-show" to more than 5 of your appointments, we may contact your referring physician to update them and require you to follow-up with them before you are able to reschedule.

Please sign below acknowledging all the above information is correct and that you agree to abide by our Appointment Policies:

X _____ Date: _____/_____/_____

Patient Name: _____ Today's Date: _____/_____/_____

Have you been treated at Scott County Physical Therapy previously? Y | N

Current Injury

Is your current injury due to any of the following (circle): Work | Auto Accident | School/School Sports | Other | None

Please briefly describe your symptoms/diagnosis/reason for physical therapy: _____

_____

Onset Date of Injury/Symptoms: _____/_____/_____ Date of Surgery: _____/_____/_____ Injured/Affected Side: R | L

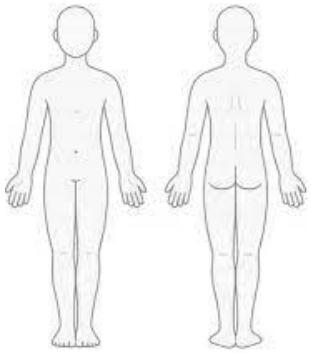
Physician Referring you for PT: _____ Next Appt. with Physician: _____/_____/_____

Have you had any testing/imagine for this episode? (circle) X-ray | MRI | CT Scan | NCS | Other: _____

Please rate your pain on a scale of 0 (no pain) to 10 (unbearable pain): Current? _____ Best? _____ Worst? _____

How are your symptoms since the onset date? (circle) Better | Worse | Same

Please ***circle and shade* the area of your pain on the diagram to the right ➡



Are you currently working? Y | N Current Height? _____ Current Weight? _____

Have you received any other therapy THIS calendar year? (PT, OT, ST, Chiro, Home Health) Y | N
If yes, how many visits? _____ Where? _____

Medical History

Have you been diagnosed with any of the following? (Please circle all that apply)

High Blood Pressure	Spinal Cord Stimulator	Cardiac Conditions	Seizures
HIV	Blood Clots	Parkinson's	Depression
Hepatitis	Vision Problems	Frequent Falls	Anxiety
Tuberculosis	Bowel/Bladder Disorder	Headaches/Migraines	Diabetes
Respiratory Problems	Osteoporosis	Pacemaker	Hearing Loss
Kidney Disease	Cancer	Currently Pregnant	Stroke/TIA
Auto Immune Disease	Rheumatoid Arthritis		

Do you smoke? Y | N Allergies? Y | N If yes, type: _____
Have you recently been admitted to the hospital? Y | N If yes, please specify: _____
Have you recently undergone any surgeries? Y | N If yes, please specify: _____

Please list all current medications (if you have a list, we would be happy to make a copy for you): _____

_____

By signing below, you are acknowledging and agreeing that all information provided above is true and accurate to the best of your knowledge. Should any of the information change, you will notify Scott County Physical Therapy as soon as possible.

X _____ Date: _____/_____/_____

Notice of Consent for Treatment, Financial Responsibility, & Privacy Practices

Please read the following statements carefully and fully. If you have any questions, please feel free to ask our office staff BEFORE signing the bottom of this page. **For patients under the age of 18:** We MUST have this form signed by the guarantor and turned into our office before we are able to start treatment. This is ***NON-NEGOTIABLE***. Without this signed form, we will have to reschedule the patient for a later date.

Consent for Treatment

I hereby authorize Scott County Physical Therapy, LLC, and any of their representatives, to provide physical therapy treatment to myself or the minor I represent. I understand that by signing this form, I am consenting to treatment provided by physical therapists, physical therapist assistants, and/or physical therapy technicians. I understand that I have the right to refuse treatment at any time, although it may affect the outcome of my overall condition.

Consent for Assignment of Benefits & Responsibility of Payment

As a courtesy to our patients, we are happy to bill your private insurance company, auto accident, and/or worker's compensation carrier on your behalf. The submission of claims is not done in our office, but they will be filed to your insurance carrier by our third-party billing provider, American Medical Computing, Inc. If any billing questions can not be answered by our office staff, you will be directed to American Medical Computing, Inc. for additional assistance. Please understand that your insurance policy and its coverage is a contract between you and the insurance provider. We are NOT a party to that contract. I hereby instruct and direct my insurance provider to release payment to Scott County Physical Therapy, LLC. This assignment will remain in effect until all insurance monies have been applied to my account and paid in full. I understand that insurance authorizations are submitted on my behalf as a courtesy to me as a patient of Scott County Physical Therapy, LLC, but I am ultimately responsible for tracking my benefit limits and authorizations.

I understand that as a patient, or guarantor of a patient, by signing below I am responsible for all payments due for services rendered by Scott County Physical Therapy, LLC. I understand that all co-pay, deductible, and co-insurance statements are due at the time of service or upon receipt of the monthly account statement mailed to my address I have provided. I acknowledge that after 90 days of non-payment on my account, I will receive a Final Notice statement for payment due. If I do not respond withing 15 days of receipt of the Final Notice, I understand that my account will be transferred to Transworld Solutions, Inc. for collection processing. I understand that I can set up automatic monthly payment plans if so agreed upon between myself and Scott County Physical Therapy, LLC, but it is my responsibility to contact the office to do so.

Consent to Release Medical Information

I hereby authorize Scott County Physical Therapy, LLC, to release all pertinent information regarding my physical therapy treatment to the below listed parties should they ask about my care or in case of an emergency. I understand that if any persons, including family members, is NOT listed below and wishes to receive information regarding the care of the patient, Scott County Physical Therapy, LLC is NOT authorized to release the requested information. The authorized list of persons may be changed at any time by re-filing this form by the patient.

Name: _____ Relationship: _____ Phone #: _____
Name: _____ Relationship: _____ Phone #: _____
Name: _____ Relationship: _____ Phone #: _____

Would you like to receive a copy of the Scott County Physical Therapy, LLC, Notice of Privacy Practices? Yes | No

By signing below, I certify that I have read and understand all the above statements and agree to the policies stated for me.

X _____ Date: _____/_____/_____