PATIENT INFORMATION

NAME: ____ DATE OF BIRTH: ____/____/_____

AGE: ________ GENDER: M / F HEIGHT: ______________ WEIGHT: ______________________

ADDRESS: ______________________________________ CITY: __________________ ZIP: _____________

HM PHONE: ______________ CELL PHONE: ______________ E-MAIL: ____________________________

SPOUSE NAME: SPOUSE PHONE: ______________________

PATIENT EMPLOYER: __________________________________ WORK PHONE: ______________________

PATIENT OCCUPATION: ____

PERSON TO CONTACT IN CASE OF EMERGENCY:

FIRST AND LAST NAME: ____________________________________ PHONE: ______________________

REFERRING PHYSICIAN: _________________________ PRIMARY PHYSICIAN: ______________________

DATE OF INJURY: ____/____/_____ DATE OF SURGERY: ____/____/_____

HOW DID YOU HEAR ABOUT US? ____ WEBSITE ____ YELLOW PAGES ____ MD REFERRAL

____ FRIEND/FAMILY ____ ADVERTISEMENT OTHER:______________________________

METHOD OF PAYMENT: ____ PRIVATE INSURANCE ____MEDICARE ____WORK COMP ____ SELF PAY

IF YOU HAVE MEDICARE, DO YOU HAVE A SECONDARY INSURANCE POLICY? YES/NO

***IF PATIENT IS A MINOR PLEASE PROVIDE US WITH THE FOLLOWING:**

PARENT/GUARDIAN: ________________________________ PARENT/GUARDIAN DOB: ___/___/_____

PARENT/GUARDIAN EMPLOYER: _________________________ WORK PHONE: ______________________

PLEASE PROVIDE US WITH A COPY OF YOUR INSURANCE CARD(S)

WAS THIS A MOTOR VEHICLE ACCIDENT? YES/NO IF YES, PLEASE COMPLETE THE FOLLOWING:

NAME OF MOTOR VEHICLE INSURANCE: _____________________________ PHONE: ________________

ADJUSTER'S NAME: ______________________________________ CLAIM #: ______________________

NAME OF INSURED: ____

DO YOU HAVE AN ATTORNEY? YES/NO IF YES, NAME: _____ _______ PHONE: ________________

HILL PRO-MOTION
PHYSICAL THERAPY

MEDICAL HISTORY

NAME: ______________________________ DATE OF NEXT MD APPT: ____/____/______

DESCRIBE THE HISTORY OF YOUR CURRENT ACCIDENT, INJURY, ILLNESS OR CONDITION:

ONSET DATE: ____/____/_______ DESCRIPTION: ______________________________

____

____

SPECIAL CONCERNS, QUESTIONS OR EXPECTATIONS: ______________________________

____

HAVE YOU FALLEN IN PAST YEAR? YES / NO IF YES, HOW MANY TIMES? ____________

IF YES, DID YOU SUSTAIN AN INJURY? ______________________________

HAVE YOU HAD ANY PHYSICAL THERAPY DURING THE CURRENT CALENDAR YEAR? YES / NO

IF YES, FOR WHAT? ________________ WHEN? ____________ WHERE? ____________

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: ______________________________

____

____

LIST ALL RECENT DIAGNOSTIC STUDIES (CAT SCAN, MRI, X-RAY, ETC.), WHEN & WHERE: ____________

____

DO YOU HAVE METAL ANYWHERE IN YOUR BODY (OTHER THAN TEETH)? YES / NO

IF YES, PLEASE DESCRIBE: ______________________________

LIST ALL SURGERIES AND DATES: ______________________________

PLEASE MARK YES (Y) OR NO (N) FOR EACH OF THE FOLLOWING:

ALLERGIES	Y	N	DIZZY SPELLS	Y	N	MRSA	Y	N
ANEMIA	Y	N	EMPHYSEMA/BRONCHITIS	Y	N	MULTIPLE SCLEROSIS	Y	N
ANXIETY	Y	N	FIBROMYALGIA	Y	N	MUSCULAR DISEASE	Y	N
ARTHRITIS	Y	N	FRACTURES	Y	N	OSTEOPOROSIS	Y	N
ASTHMA	Y	N	GALLBLADDER PROBLEMS	Y	N	PARKINSON'S	Y	N
AUTOIMMUNE DISORDER	Y	N	HEADACHES	Y	N	RHEUMATOID ARTHRITIS	Y	N
CANCER	Y	N	HEARING IMPAIRMENT	Y	N	SEIZURES	Y	N
CARDIAC CONDITIONS	Y	N	HEPATITIS	Y	N	SMOKING	Y	N
CARDIAC PACEMAKER	Y	N	HIGH CHOLESTEROL	Y	N	SPEECH PROBLEMS	Y	N
CHEMICAL DEPENDENCY	Y	N	HIGH / LOW BLOOD PRESSURE	Y	N	STROKES	Y	N
CIRCULATION PROBLEMS	Y	N	HIV / AIDS	Y	N	THYROID DISEASE	Y	N
CURRENTLY PREGNANT	Y	N	INCONTINENCE	Y	N	TUBERCULOSIS	Y	N
DEPRESSION	Y	N	KIDNEY PROBLEMS	Y	N	VISION PROBLEMS	Y	N
DIABETES	Y	N	METAL IMPLANTS	Y	N			

SIGNATURE: ______________________________ **DATE:** ____/____/______

AUTHORIZATION TO TREAT/FINANCIAL POLICY

****PLEASE INITIAL THE FOLLOWING:**

____ I HEREBY AUTHORIZE HILL PRO-MOTION PHYSICAL THERAPY TO PROVIDE TREATMENT AS PRESCRIBED BY MY PHYSICIAN AND CONSENT TO EVALUATION AND TREATMENT PROCEDURES WHICH MAY BE DEEMED ADVISABLE BY MY PHYSICIAN FOR MEDICAL CARE PROVIDED BY HILL PRO-MOTION PHYSICAL THERAPY. I UNDERSTAND A VARIETY OF TREATMENT OPTIONS AND TECHNIQUES MAY BE USED. I UNDERSTAND THAT NO ASSURANCE CAN BE GIVEN THAT THE COURSE OF TREATMENT WILL IMPROVE MY CONDITION.

____ I HEREBY ACKNOWLEDGE HILL PRO-MOTION PHYSICAL THERAPY WILL ENACT A CANCELLATION FEE OF $25.00 FOR EACH VISIT THAT IS CANCELED WITHOUT 24 HOURS NOTICE OR FOR A "NO-SHOW".

____ I HEREBY ASSIGN ALL INSURANCE BENEFITS FOR SERVICES RENDERED TO WHICH I AM ENTITLED TO BE PAID DIRECTLY TO HILL PRO-MOTION PHYSICAL THERAPY. I UNDERSTAND THAT IF MY INSURANCE COMPANY/THIRD PARTY PAYER DENIES PAYMENT OR MAKES PARTIAL PAYMENT, I AM RESPONSIBLE FOR THE BALANCE DUE.

____ I HEREBY AUTHORIZE THE RELEASE OF MEDICAL RECORDS TO HILL PRO-MOTION PHYSICAL THERAPY AND ANY PERTINENT INFORMATION CONCERNING THE PATIENT FOR THE PROVISION OF CARE AND FOR OBTAINING INSURANCE REIMBURSEMENT.

____ I UNDERSTAND THAT AS A COURTESY, HILL PRO-MOTION WILL VERIFY MY COVERAGE BUT THAT I AM LEGALLY RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED BY HILL PRO-MOTION PHYSICAL THERAPY. IF MY INSURANCE IS BEING BILLED, I WILL BE RESPONSIBLE FOR PAYING ANY DEDUCTIBLE AMOUNTS. I UNDERSTAND THAT CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE. (THIS DOES NOT APPLY TO WORKER'S COMPENSATION PATIENTS.)

SIGNATURE OF PATIENT/GUARDIAN: ______________________________ DATE: ____/____/________

ACKNOWLEDGMENT OF RECEIPT

A. I have received a copy of this office's Notice of Privacy Practices YES / NO Initial __________

B. I agree that PT/PTA students may participate in my physical therapy care. YES / NO Initial __________

As a courtesy, we will gladly bill your insurance company for you. However, you are responsible for the total balance due. Ultimately, it is your responsibility to check your insurance benefits regarding deductibles and co-pays. Any disputed claims are between you and your insurance company. We will be happy to provide your insurance company with any information that is needed to process your claim(s).

SIGNATURE OF PATIENT/GUARDIAN: ______________________________ DATE: ____/____/______

PRINT NAME: ____