Physical Therapy Specialists, P.C.

915 Pierce Street, Sioux City, IA 51101

150 Tower Road Ste.115, Dakota Dunes, SD 57049

|  |  |  |  |
| --- | --- | --- | --- |
| Patient Name |  | Date of Birth |  |
|  | FIRST | MI | LAST |  |
| Address |  |
|  | STREET | CITY/STATE | ZIP |
| Social Security # |  | **** Female **** Male **** Minor ****  Single **** Married |
|  |  |  |  |  |
| Home Phone# |  | Work Phone# |  | Cell Phone # |  |
| Preferred # to Call: | **** Home **** Work **** Cell | Preferred Method of Contact: | **** Call **** Text/SMS |
| E-mail Address |  |
|  |  |  |  |  |
| Patient/Parent/Guardian’s Employer |  |
|  |  |  |  |  |
| Emergency Contact Name: |  | Relationship to Patient: |  |
| Emergency Contact Phone #: |  |  |  |
|  |  |  |  |  |  |
| **Liability related?** | **** Yes **** No | **Job related?** | **** Yes **** No | Date of Injury/Surgery |  |
| **Have you been seen by a Home Health Agency in the last 30 days?** | **** Yes **** No | If yes, by whom? |  |
|  |  |  |  |  |
| **IF UNDER 18****RESPONSIBLE PARTY** |  |  |  |  |
| Parent/Guardian Name: |  |
|  |  |  |  |  |
| Relationship to Patient: |  | Parent/Guardian DOB: |  | Phone # |  |
|  |  |  |  |  |
| **PRIMARY INSURANCE** |  |  |  |  |
| Policy Holder: |  | Policy Holder DOB: |  |  |
|  |  |  |  |  |
| Relationship to Patient: |  |
|  |  |  |  |  |
| **SECONDARY INSURANCE** |  |  |  |  |
| Policy Holder: |  | Policy Holder DOB: |  |  |
|  |  |  |  |  |
| Relationship to Patient: |  |
|  |  |  |  |  |
| * **I authorize Physical Therapy Specialists, P.C. (PTS) to furnish my insurance company, including Medicare, with all information relating to this illness or injury. I authorize payment to be made to PTS by commercial government insurance for physical therapy treatment and supply expenses rendered but not to exceed my indebtedness.**
* **I understand that I am financially responsible to PTS for all expenses incurred.**
 |
|  |  |  |  |  |
| **Signature** |  | **Date** |  |

Physical Therapy Specialists, P.C.

**THANK YOU FOR CHOOSING OUR OFFICE!**

Just a few reminders to assist us in providing you with the best possible care, allowing you our full attention, and accurate and timely filing with your insurance.

**Please call to cancel or reschedule 24 hours in advance.**

**Please initial: \_\_\_\_\_\_**

Also, please be prompt for your scheduled appointment time.

The following is clinic policy for payment for therapy services:

1. Co-pays are due at each appointment.
2. If you have a deductible or co-insurance to meet, we will collect each visit until the amount is satisfied.
3. Any delinquent account will be sent to a collection agency.
4. Questions regarding billing and financial arrangements should be directed to our billing manager.

**Consent to Treatment**: I consent to receive physical therapy treatment and any supplementary services that are deemed medically necessary or appropriate by my physical therapist.

**Please initial: \_\_\_\_\_\_**

**Privacy Practices Acknowledgement**

I acknowledge that I have received a copy of Physical Therapy Specialists, PC's Notice of Privacy Practices which summarizes the ways my identifiable patient health information may be used and disclosed by Physical Therapy Specialists, PC and states my rights with respect to my medical information. I have been informed that in the event that Physical Therapy Specialists, PC revises its information practices, a revised Notice will be posted at the clinic and that I may obtain a current Notice of Privacy Practice at any time.

Patient/Parent/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_

Witness signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_

Copy given to patient \_\_\_\_\_\_\_\_\_\_\_\_

Physical Therapy Specialists, P.C.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Chief Complaint for this visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Currently working: Yes No

If not currently working, last date worked: \_\_\_\_\_\_\_\_\_\_ If working, list any restrictions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tests completed to diagnosis this problem: X-rays MRI Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had previous therapy for this problem? Yes No

 If Yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please circle the severity of your pain: 0 1 2 3 4 5 6 7 8 9 10

 No Pain Moderate Strong Very Strong Maximal

Do you currently have or have had a history of any of the conditions below?

High blood pressure Yes No Cancer Yes No

Diabetes Yes No Seizures/Epilepsy Yes No

Migraines Yes No Strokes Yes No

Alzheimer’s Yes No Tremors Yes No

Multiple Sclerosis Yes No Arthritis Yes No

Heart Disease Yes No Infection/MRSA Yes No

Blood Clots Yes No AIDS/HIV Yes No

Heart Attack Yes No Hepatitis Yes No

High Cholesterol Yes No Liver Disease Yes No

TB Yes No Bladder Problems Yes No

Asthma Yes No Psychological Problems Yes No

Thyroid problems Yes No Pacemaker Yes No

Are you currently pregnant? Yes No If yes, when are you due? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any other medical conditions we need to be aware of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any medications and dosage you are currently taking:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergic to any medications? Yes No If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_