New Patient Information Form

Name: _____ Date Of Birth: _____

Home Address
Street: _____ Apt. _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____
Best Email : _____@_____
Emergency Contact: _____ Phone: _____

How did you hear about us? _____

Physician Information

Referring Physician: _____ Location: _____
Phone: _____ Fax: _____
PCP: _____ Location: _____
Phone: _____ Fax: _____

Insurance/ Injury Information

Is this injury employment related? YES / NO.
Is this injury due to a Car Accident? YES / NO. DOA: _____

Insurance: _____ Type: ____ Policy #_____
Secondary Insurance _____ Type: ____ Policy #_____
Subscriber Name: _____ D.O.B _____

Do you have any of the following?
- Deductible (If so, how much and has it been met?) _____
- Co-pay (If so, how much?) _____
- Co-insurance (If so, what percentage?) _____

Work Information
Employer: _____ Address: _____ Phone: _____

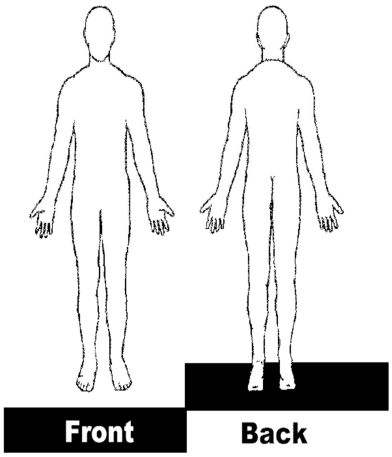
HOW WOULD YOU LIKE TO RECIVE YOUR APPOINTMENT REMINDER? Email/ Text

***** Please Present your insurance card for photocopying*****

Health History Form

Patient's Name: _____ Date: _____

Place an "X" where you have pain:



Circle the line below to rate your current pain:

When did your pain begin? _____ What caused your pain? _____

Have you had physical therapy in the past 12 months? YES/NO Where? _____

Are you currently receiving Home Health Services? YES/NO Company Name: _____

Did you receive Cortisone injection in the last 6 months? YES / NO

Medical History: Please check, if you have or have ever had any of the following?

____ Pacemaker
____ Heart related issues
____ High blood pressure
____ Lung disease/breathing issues
____ Diabetes
____ History of cancer (type: _____)
____ Unexplained recent weight loss
____ Increased pain at night
____ Recent increase in headaches
____ Changes in sensation (numbness/tingling)
____ Circulation or vascular problems
____ Neurological problems (ex: seizure/stroke/MS)
____ Osteoporosis/low bone density
____ History of fractures/broken bones
____ Vision or hearing problems
____ MRSA/Staph infection
____ Arthritis
____ Unusual dizziness
____ Kidney problems
____ Changes in bowel/bladder function
____ Recent falls
____ Drug or alcohol abuse issues
____ Depression
____ Other: _____

(Female Patients) Are you currently pregnant? **YES / NO**

Please List ALL Current Medications:

Medication	Dosage	Frequency	Method of administration

Please List ALL Surgeries and Approximate Dates:

surgery	Date

Patient's Signature: _____ Date: _____

Therapist's Signature: _____ Date:_____

Patient Consent Form / Notice Of Privacy Practice Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at their address to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to patient:_____Date:_____

For Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

_____	_____	_____
Date	Name	Reason

Important Company Policies

At Wellbridge Physical Therapy we strive to provide you the best personalized care available.

To make this possible we adhere to a set of very important guidelines.

Please read them carefully, initial all boxes, and indicate your agreement by signing at the bottom.

- **"15- Minutes" Late Policy**
  Being late by more than 15 minutes will require you to either reschedule your appointment of wait for the next available opening.

- **24- Hour Advance Notice Fee**
  If you wish to change or cancel an appointment we require a minimum 24-hour advance notice. Anything less will result in a 10$ fee charge to your account. It costs us money to make appointments available to you. Whether you attend or not we still accrue the expenses (for staff wages, rent. Etc.). Advance notice allows someone else to reserve that time.

- **Co-pays are due upon arrival**
  Please have cash, check or credit card with you to make your co-pay at time of service.

- **25$ No-Show fee**
  If you fail to show for an appointment without notice all future appointments will be removed and a 25$ fee assessed to your account. You may re-schedule appointments again in a 'first come, first serve' basis.

- **Cell phones must be shut OFF or silent**
  We realize emergencies may arise and therefor allow you to carry your cell phone during your session, however, cell phone conversations are disruptive to treatments so we ask you to please be courteous and set to silent mode or turn off.

- **Financial hardship**
  if you are experiencing financial difficulties and are unable to afford the cost of our services we may be able to work out a payment plan with you. Please speak with the office manager for details.

We look forward to building a successful relationship with you that lasts a lifetime!

Signature: _____ Date: _____

Patient Financial Responsibilities

- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for their treatment and care.

- We are pleased to assist you by billing for our contracted insurers. However, the patient is required to provide us with the most correct and updated information about their insurance, and will be responsible for any charges incurred if the information provided is not correct or updated.

- Patients are responsible for the payment of co-pays, co-insurance, deductibles and all other procedures or treatment not covered by their insurance plan. Payment is due at the time of service and for your convenience; we accept cash and most major credit cards at our office.

- Patients may incur and are responsible for the payment of additional charges. These charges may include:

    - Charge for missed appointments without 24-hours advance notice.
    - Any costs associated with collection of patient balances.

- By my signature below, I hereby authorize **Wellbridge Physical Therapy** and staff to release medical and other information acquired in the course of my examination and/or treatment to be necessary insurance companies, third party payers and/or other physicians or healthcare entities required to participate in my care.

- By my signature below, I understand that I am financially responsible for charges not covered by my health insurance.

_____

Signature of patient or guardian Date