WELLBRIDGE
PHYSICAL THERAPY

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:** _____

Release of Information:

I hereby authorize Wellbridge Physical Therapy to discuss my personal healthcare information regarding my treatment including diagnosis/prognosis, billing and payment for services rendered on my behalf, and scheduling to the person(s) listed below:

_____ _____ _____

Name (print) **Relationship** **Phone number**

_____ _____ _____

Name (print) **Relationship** **Phone number**

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:** _____

Have you received homecare in the last 6 months? **YES/NO**

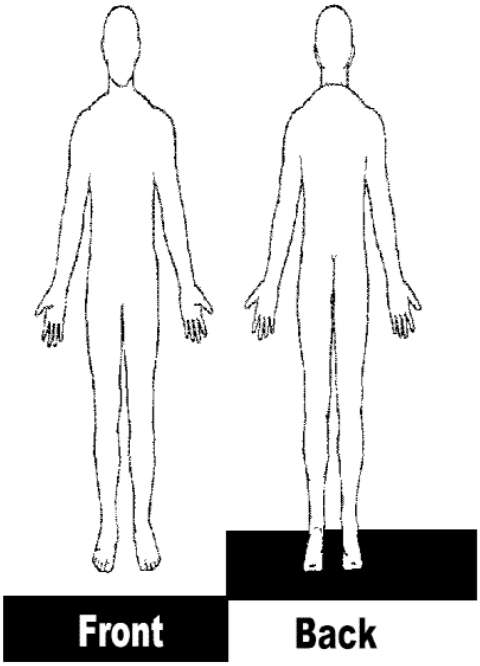
How did you hear about us? _____

HOW WOULD YOU LIKE TO RECEIVE YOUR APPOINTMENT REMINDERS? **Email/ Text**

*****Please present your insurance card for photocopying*****

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 ____ Arthritis
____ 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

____ 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

Patient's Name: _____

Medication	Dosage	Frequency	Method of administration

Please list ALL current medications:

Please list ALL surgeries and Approximate Date:

Surgery	Date

Patient's Signature: _____ **Date:** _____

New Patient Acknowledgements

Patient Name:_____

Consent to Treatment

_____ Initial I consent to and authorize Wellbridge Physical Therapy to administer rehabilitation therapy treatment. I understand and am informed that, as in the practice of medicine, rehabilitation therapy may have some risks. I understand that I have the right to ask about these risks and have any questions about my conditions answered prior to treatment. I know it is up to me to inform my provider of rehabilitation therapy about any health problems or allergies I have, as well as medications I am taking. I understand that the practice of rehabilitation therapy is not an exact discipline, and I acknowledge that no guarantees have been made to me regarding treatment and/or treatment results from the rehabilitation therapy.

Notice of Privacy Practices

_____ Initial I hereby acknowledge that I have been made aware of Wellbridge Physical Therapy's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is available at the front desk, and that I may request a copy of any amended Notice of Privacy Practices at any time. I understand that I may request in writing that you restrict how my private information is used and 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 acted relying on this consent.

Authorization to Release / Obtain Information

_____ Initial I hereby authorize the release of my patient health care information for the purposes of treatment or payment, to my physician, insurance company, adjustor, attorney, or other health care organizations pertinent to my case. Further, I authorize Wellbridge Physical Therapy to obtain needed information from my physician, insurance company, adjustor, attorney and any other health care organization pertinent to my case. This correspondence can be made via mailings, telephone and/or facsimile.

New Patient Acknowledgements Appointments / Cancellations

_____ Initial We advise you to schedule your appointments in advance. Maintaining a consistent schedule ensures your best outcome for a speedy recovery. Being late by more than 15 minutes will require you to either reschedule your appointment or wait for the next available opening. We expect you to keep all of your appointments with Wellbridge Physical Therapy and require 24 hours notice if you are unable to keep an appointment, anything less will result in a $25 charge to your credit card on file. Failure to show up for an appointment with no notice will result in a $50 charge to your credit card on file. These charges are not reimbursed by any insurance company.

Financial Responsibility

_____ Initial Co-pays are due at the time of treatment. I agree to pay Wellbridge Physical Therapy all amounts that are due for services rendered which are not otherwise paid for by my insurance plan on my behalf. In the event that my account is referred to a collection agency or an attorney, I further agree to pay all reasonable costs incurred to collect any amounts that are due for services rendered including, without limitation, reasonable attorney's fees.

If you are experiencing financial hardship 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.

Assignment & Release of Benefits

_____ Initial I hereby appoint Wellbridge Physical Therapy as my authorized representative, and assign to it my right, to file for, receive and recover any and all monies payable for the care which it rendered to me from any third party claims payment source, including my health insurer, Medicare, Medicaid or other governmental program (collectively, my "Plan"), while I was eligible to receive such claim payment. I authorize you to send and receive documentation related to my treatment to, and consent to your discussing my treatment with, my Plan." I also authorize Wellbridge Physical Therapy to take any and all actions necessary to assert and pursue my legal rights to receive such claim payment under the terms of my Plan through any appeals and/or grievances and/or litigation and/or arbitration available to me for such purpose. As the assignor of the foregoing payment amounts, I direct that such payment be sent by my Plan to Wellbridge Physical Therapy and, in the case that payment is made by my Plan to me, I agree to remit such payment in full to Wellbridge Physical Therapy no later than ten (10) days after my receipt.

Insurance Eligibility

_____ Initial Verification of benefits is NOT a guarantee of payment. Payment is determined by your insurance company at the time a claim is received. We provide you with the information as it is outlined by your insurance company. It is your responsibility to fully understand your insurance benefits.

Primary Insurance: _____ HMO/PPO

Deductible_____ Remaining_____

Out-of-Pocket_____Remaining_____

Copay_____ Coinsurance_____ Prior Authorization Required_____

Secondary Insurance:_____HMO/PPO

Patient Signature (Parent/Guardian if patient under 18 years) _____

Printed Name _____ Date_____

PATIENT INFORMATION RE: CREDIT CARD ON FILE POLICY

As you are aware, healthcare has undergone dramatic changes in the past few years. High-deductible health plans are now a mainstay in the healthcare landscape. This means that more responsibility of the payment is being placed on patients. We need to be sure that patient balances are paid in a timely manner. If you have ever stayed in a hotel or rented a car you are familiar with the concept of having a credit card on file. Your credit card information is stored in a secure, encrypted manner and only accessed and charged if there is an outstanding balance. As of January 1, 2025, Wellbridge Physical Therapy has adopted a Credit Card on File Policy.

At the time of registration, we will request your credit card information. Your credit card numbers will be encrypted and stored securely. Once we receive your Explanation of Benefits (EOB) (what the insurance company will pay towards your visit), we will wait 30 days to allow you time to pay the balance on your account. If your balance is not paid your credit card will be charged for the outstanding balance that is your responsibility. Co-pays must be paid at the time of visit. If you have any questions about this payment method, please do not hesitate to contact us at 603-488-5808.

How does credit card on file benefit me?

Using credit card on file, you will be able to:

- Pay balances and co-pays conveniently
- Make payments automatically using your credit card of choice
- Avoid writing checks to pay bills by mail
- Receive notifications and receipts via email
- Keep bills paid to avoid collecting a large balance

Your credit card on file can be used for the following reasons:

- Co-pays
- Co-pays not collected from you at the beginning of the visit
- No show or late cancellation fees
- Outstanding balances greater than 31 days past due

_____ _____ _____

Credit Card Number | Exp Date | Name as it appears on card

_____ _____ _____ _____

Billing Address | City | State | Zip

_____ _____ _____ _____

Patient Name | Patient DOB | Patient Name | Patient DOB

I authorize Wellbridge Physical Therapy to charge the above credit card above per the terms of this policy. This authorization shall remain in effect until WBPT has received written notification from me of its termination.

_____ _____

Signature | Date

Unfortunately, we are unable to book future appointments if this form is not accurately filled out and signed.