Welcome to All Around Physical Therapy

New Patient Information

Name: _____ Female / Male

Date:_____What you prefer to be called: _____Age: _____

Date of birth: _____ Address: _____

City: _____State:_____Zip: _____ Home Phone: _____

Cell Phone: _____ Email Address: _____

SS#: _____ Employer: _____

Occupation:_____ Work Phone: _____

Emergency Contact: _____Relation: _____

Phone: _____

How did you hear about our office?

_____

When did your condition begin?

_____

Other Doctors/Hospitals seen for this condition?

_____

Have you had the same or similar symptoms before? Yes No

Date of prior condition _____

List Areas of Pain and/or symptoms below in order of severity:

(1) _____

(2) _____

(3) _____

(4) _____

(5) _____

Family Physician: _____

May we forward our findings to your doctor? Yes No

Current Medications: _____

_____

Allergies (Medicine, Food, Environment):

_____

Previous Surgeries:

_____

Do *YOU* have a PERSONAL history of: Cancer, Diabetes, Heart Disease, Stroke, Other serious illnesses?

_____

Circle all symptoms that apply to you: Headache, Tingling/numbness in arms/hands, Chest Pain, Unexplained weight loss, Neck Pain/Stiffness, Tingling/numbness in legs/toes, Fatigue Back Pain/Stiffness, Loss of balance/dizziness, Night Sweats, Shortness of breath, Fever, Blood in Urine, Other _____ Night Pain, Pain unrelieved by rest.

For women: Are you pregnant? Yes No **Are you taking birth control?** Yes No

Health Insurance Policy Holder Name: _____
Policy Holder's Date of Birth: _____

WORKER'S COMPENSATION:

Did your injury happen during your work-shift? Yes No Have you reported it? Yes No
Do you have a claim number? YES NO #_____ Date of accident: _____
Supervisor: _____Supervisor #_____

AUTO ACCIDENT:

Is your condition due to Automobile Accident? Yes No Date of accident _____

Auto Accident Insurance Name _____ Claim # _____ Adjuster Name _____Phone #_____ Attorney Name _____Phone #_____

INSURANCE INFORMATION, CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION:
I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are changed directly to me and that I am personally responsible for payment. I also understand if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I hereby authorize Anthony Plescia, DPT, All Around Physical Therapy & Wellness, and their affiliated providers to administer treatment, physical examination, X-ray studies, laboratory procedures, chiropractic care, physical therapy, or any clinic services that they deem necessary in my case; I do hereby give my consent for the performance of conservative non-surgical treatment, including, but not limited to manipulation, physical therapy modalities, soft tissue massage and therapeutic exercises. I am aware there are possible risks and complications associated with these procedures, ranging from soreness to stroke. I understand there is no certainty that I will achieve benefits and acknowledge that no guarantee has been made regarding the outcome of these procedures. I am aware there are alternatives to these procedures, including medication and/or surgery. I further authorize them to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to hospital or medical services companies, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

I understand that if an insurance company initially pays for my treatment and later requests reimbursement from All Around Physical Therapy & Wellness for any reason, I will be responsible for payment of my entire outstanding balance.

We invite you to discuss any questions you might have with us. The best health services are based on a friendly mutually understood relationship.

Patient or Guardian's Signature: _____

Date: _____

CO-PAY

Please- it is your obligation to pay your co-pay payment at the time of service. Due to insurance guidelines and regulations, we must collect co-pay for every office visit. Please remember we accept cash checks, MasterCard, Visa, and Discover.

Non-covered Services

Please be aware that some – and perhaps all – of the services provided may not be covered or may be applied to your deductible by your insurance company. You will be responsible for payment.

Claims Submission

We will submit your claims to your insurance company and assist you in any way we can to help get your claims paid. Your insurance company may need to supply certain information directly to them. Please do so promptly. However, any unpaid balance is your responsibility.

Coverage Charges

Please notify us if your insurance changes before your next visit so we can make all of the appropriate changes to help you receive your maximum benefits.

Non-payment

We understand that these are difficult economic times. Please talk to us about setting up a payment plan that you can afford. Any unpaid balances may be forwarded to a collection agency. We make every attempt to contact you by main and phone but it is your responsibility to contact us to set up a payment plan or update insurance information.

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

CONSENT TO TREAT A MINOR: I (we) being the parent, guardian or custodian of the minor being _____, age _____, do hereby authorize, request & direct All Around Physical Therapy & Wellness, it's doctors and staff to perform examinations, diagnostic x-rays, laboratory tests, and any treatment that in their judgment, is deemed advisable or required. It is the understanding of the undersigned that the physicians and their staff will have full authority from me as legal parent/guardian to continue with examinations, diagnostic tests, and treatments as will be needed while said minor shown above is under care in this office until legal age is attained. As legal parent/guardian, I realize full responsibility for all charges and payments due.

Parent/Guardian or Custodian Signature: _____ **Date Signed:** _____

Witness: _____

HIPAA COMPLIANCE PATIENT CONSENT FORM: I understand that under the Health Insurance Portability and 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: 1) Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly. 2) Obtain payment from designated third-party payers. 3) Conduct normal health care operations such as quality assessments or evaluations 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 (available in the office in print form). I have reviewed such Notice of Privacy Practices prior to signing this consent, and acknowledge that I have studied the Privacy Practices prior to signing this consent, and acknowledge that I have studied the Privacy Practices. 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 the address above to obtain a current copy of the Notices of Privacy Practices. I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that the organization has acted relying on this consent.

Patient's Name: _____ **DOB:** _____

Signed (Patient or Legal Representative for Patient):

_____ **Date:** _____

Legal Representative's Relationship to Patient:

_____