TEAM™ PHYSICAL THERAPY P.C.

Together Empowering Able Movement

NEW PATIENT HEALTH INFORMATION

Please fill in all lines so we can assist you better.

Today's Date: _____

Patient Full Legal Name: _____ Nick Name: _____

Birth Date: _____ Age Today: _____

Street Address: _____ Mailing Address: _____

City: _____ State: _____ Zip: _____ SSN: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Occupation: _____ Employer: _____ Employer City/State: _____

Referring Doctor: _____ Family Doctor: _____

Date of last Dr. visit: _____ Date of onset of pain: _____

Area to be treated: _____

Reason for Treatment (*what caused the pain/problem? Be specific*):

Are you currently receiving home health services? Yes/No Last date of home health: _____

Have you fallen in the last 12 months? Yes / No With injury? Yes / No

Is your visit today due to surgery? Yes / No Date of Surgery: _____

Is your visit today due to an accident? Yes / No Date of accident _____

*Work related injury Yes / No *Motor vehicle accident: Yes / No *Liability Claim Yes / No

**If you answered Yes to the above accident questions, please complete Work Comp/Liability Authorization.*

PATIENT HEALTH HISTORY: PLEASE BE AS SPECIFIC AS POSSIBLE

	YES	NO	Explain:		YES	NO	Explain:
Pacemaker or Defibrillator				**Allergies to Latex/Lotions/perfumes**			
Currently Pregnant				Osteoporosis			
Depression				Cancer			
Bipolar Disorder				Stroke			
Diabetes				Seizures			
Dementia				Neurologic Issues			
COPD/Emphysema				How much/often do you exercise:			
Asthma							
Headaches				Past Surgeries (please list):			
Arthritis							
High Cholesterol							
High Blood Pressure							

For office use:

Pain rating:	Dx:	Functional Test/Score:

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AUTHORIZATION AND CONSENT FOR TREATMENT

PATIENT'S NAME: _____ TODAY'S DATE: _____
I hereby authorize TEAM Physical Therapy, P.C. staff to administer all outpatient physical or occupational therapy treatments and procedures deemed medically necessary.

I hereby authorize TEAM Physical Therapy, P.C. to provide copies of my physical therapy notes/medical record as requested by my insurance/assurance company, attorney or any other outside source representing me. I understand that I am responsible for the cost of postage/copying fees for these documents.

The following person(s) or organization(s) are authorized to receive my health information.
Name: _____Relationship: _____
Name: _____Relationship: _____

In the event of an emergency, I request TEAM Physical Therapy, P.C. contact the following:
Name: _____ Phone: _____ Relationship: _____

I have been offered a copy of TEAM Physical Therapy, P.C. Notice of Privacy Practices, Bill of Rights & Responsibilities, and Financial Policy.

I understand, according to the financial policy, that my account is to be paid in full within six (6) months of the last date of service. If I am unable to pay within six (6) months, I must contact the billing office promptly to discuss the account balance and set up a payment plan.

Do you want a Bank Card / Credit Card / or Health Savings Account card on file to pay your copays or balance due on your account? **YES / NO**
If yes: *Please complete an Automatic Payment Authorization form to enroll in our auto pay program.*

I understand I am responsible for payment of all services rendered on my (or my dependent's) behalf. I will keep my account current and settle any discrepancies with my insurance company personally. I understand any unpaid balance on my account (after the due date) will incur a 1.33% monthly late fee charge (16% annual) that will be added to my outstanding balance that I am also responsible for. Missed payments may lead to my account being released to a collection agency. Any checks that bounce from my account may be turned over to the county attorney for collection. If a settlement or lawsuit is pending regarding your injury you will be responsible for making monthly payments on your account until the balance is paid in full.

The undersigned has read and completed all the above information accurately.

Signed: _____OR_____
Patient (must be 19) Authorized person / relationship to patient
Date: _____ Time:_____ A.M. / P.M. Witness: _____