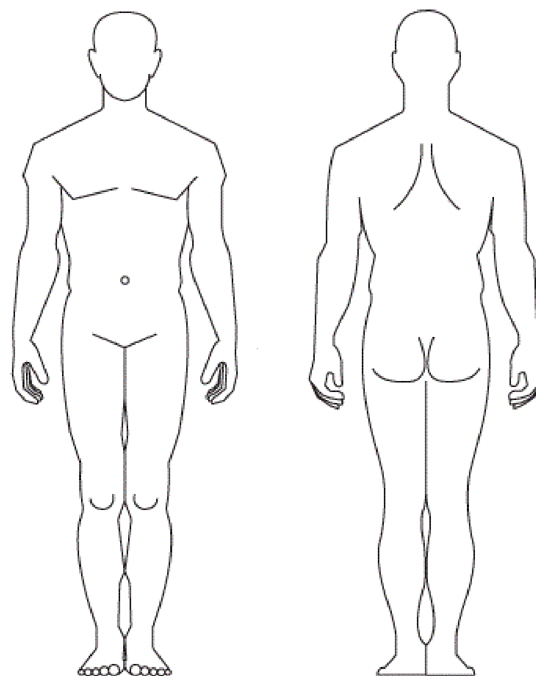
Affiliated THERAPY

NAME: ______________________________ DATE OF BIRTH (DOB): ______________ GENDER: M ☐ F ☐
STREET ADDRESS: ____ CITY: ____________
STATE: ______ ZIP: _________ PHONE 1 ( ) _______________ PHONE 2 ( ) ____________
SOCIAL SECURITY # ____________________ EMAIL ADDRESS: ______________________________
EMERGENCY CONTACT: ____________________________ EMERGENCY PHONE ( ) _____________
PHYSICIAN: ____________________________________ PHYSICIAN PHONE ( ) ______________
HOW DID YOU HEAR ABOUT US? ____
CHIEF COMPLAINT/BODY PART TO BE TREATED: ____

HAVE YOU RECEIVED THERAPY/HOME HEALTH FROM A DIFFERENT PROVIDER WITHIN THE LAST 2 MONTHS YES ☐ NO ☐
WE PROVIDE COURTESY APPOINTMENT REMINDERS. DO YOU PREFER: PHONE CALL, TEXT OR EMAIL? ____________

1 How would you rate your overall health? ○ Good ○ Fair ○ Poor

2 Indicate on the drawings to the right where you have pain/symptoms.



3 How would you describe the type of pain?

- ○ Sharp
- ○ Dull
- ○ Achy
- ○ Burning
- ○ Shooting
- ○ Stiff
- ○ Numb
- ○ Other: ______________________________

4 How are you symptoms changing with time?

- ○ Getting worse
- ○ Staying the same
- ○ Getting better

5 How would you rate your pain/problem? (0 being no pain/problem).

0 1 2 3 4 5 6 7 8 9 10

6 Are you pregnant? NO☐ YES: Due date: ________________

7 List relevant surgical procedures and dates: ______________________________________

____

____

8 Have you had any falls in the last 6 months? NO☐ YES: How? ________________________

____

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9 Check the box if you have any of the following:

Condition	☐
AIDS/HIV	
Alcoholism	
Anemia	
Angina	
Arthritis	
Asthma	
Cancer	
Chemotherapy	
Diabetes	
Difficulty Breathing	
Drug Abuse	
Elbow/upper arm pain	
Emphysema	
Epilepsy	
Frequent neck pain	
Glaucoma	
Gout	
Heart Attack	
Heart Disease	
Heart Murmur	

Condition	☐
Hepatitis	
Herniated Disk	
High/Low BP	
Kidney Problems	
Multiple Sclerosis	
Osteoporosis	
Pacemaker	
Parkinson's Disease	
Polio	
Prosthesis	
Psychiatric care	
Rheumatic Fever	
Rheumatoid Arthritis	
Seizures	
Shingles	
Stroke	
Tuberculosis	
Tumors / Growths	
Ulcers	
Venereal Disease	

10 Who else have you seen for your problem?

- ○ Chiropractor
- ○ Neurologist
- ○ Orthopedist
- ○ Physical Therapist
- ○ Primary Care Physician
- ○ ER Physician
- ○ Other:______________________________

11 How long have you had this problem, and how did it begin? ____________________

12 What aggravates your problem?______________________________

____

13 What concerns you the most about your problem and what does it prevent you from doing?________________

____

14 List all prescriptions and over-the-counter medications you are currently taking: ________________

____

____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that Affiliated Therapy complies with HIPAA and will protect my Protected Health Information (PHI) and will use it as allowable by law in the treatment, billing and collection pertaining to my care until my case is closed and full payment is received. I also authorize the release of any information pertinent to my case to any insurance company, adjustor or attorney for the purpose of securing payment under this policy of insurance or to any Medical Provider associated with my case to effectively treat me. A photocopy of the assignment is to be considered as valid as the original. The authorization is in effect until 90 days for the date the last bill is collected.

FINANCIAL POLICY STATEMENT

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered unless prior arrangements have been made. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not send payment within 120 days, you are responsible for the balance. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. If any payment is made directly to you for services billed by us, you recognize an obligation to promptly send payment to Affiliated Therapy.

The above does not apply for those patients that are treated under Worker's Compensation and Attorney Liens. However, be advised that if you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you. If you fail to make any payments for which you are responsible, in a timely manner, you will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees. I, the undersigned, do hereby assign all medical benefits to include private insurance and third party payers to Affiliated Physical Therapy.

Patients with Cancelled or No-Show appointments
with less than a 24-hour notification are subject to a $25.00 fee.

(I UNDERSTAND THE ABOVE INFORMATION AND GUARANTEE THIS FORM WAS COMPLETED CORRECTLY TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES TO MY MEDICAL STATUS.)

CONSENT TO TREAT

I hereby authorize the professional staff at Affiliated Therapy to examine and treat me with physical therapy for the injury that I have been referred here for or referred myself to.

____

Patient Printed Name

____ ________________

Signature of Patient or Patient Representative Date

AUTHORIZATION ON BEHALF OF

I hereby authorize ______________________________ to contact Affiliated Therapy on my behalf regarding my care and /or treatment.

____ ________________

Signature of Patient Date