Patient Medical Information

Patient Name:______________________________ Age: ______________ Today's Date: ___ /___ /______

What is your reason for coming to Physical Therapy today? ___________________________________

____

What are your goals and expectations for physical therapy? ___________________________________

____

Current Injury, Surgery, or Pain

Height: _____________ Weight: ____________

Date of Injury: _______________ Date of Surgery: _______________ Date Pain Started: __________

Referring Physician: ________________________ Last MD Visit: ___________ Next MD Visit: _______

Is your injury related to any of the following?

☐ Work ☐ Car accident ☐ Surgery ☐ Lifting/Carrying ☐ Fall

☐ Slow onset ☐ Athletics ☐ Chronic/Reoccurring

Occupation: ______________________________________ Work Status: ☐ FT ☐ PT ☐ Unemployed

Diagnostics performed for this condition? ☐ X-ray ☐ MRI ☐ CT Scan ☐ EEG ☐ EMG ☐ Injections

If yes, date: ___________________

Have you received treatment for your condition before today? If yes, from whom: ___________________

☐ Medical Doctor ☐ Chiropractor ☐ Physical Therapist

☐ Other: __________________

Have you recently experienced any of the following:

☐ Dizziness/Lightheaded ☐ Difficulty swallowing ☐ Muscle weakness

☐ Fainting ☐ Changes in bowel or bladder ☐ Numbness/Tingling

☐ Unexplained weight loss ☐ Incontinence ☐ Are you pregnant, # wks_______

Allergies

Please list any allergies :

Have you ever been diagnosed with any of the following?

☐ High/Low blood pressure
☐ Heart problems
☐ Stroke/CVA
☐ Pacemaker
☐ Blood clots/Circulation issues
☐ Diabetes: Type 1/Type 2
☐ Osteoporosis
☐ Arthritis: OA/RA
☐ Cancer
☐ Bladder/Urinary/Kidney Disease

☐ Lung Problems
COPD / Emphysema
☐ Tobacco use: #_____/day
☐ Asthma
☐ Seizures
☐ Neurological disease:
MS / Parkinson's
☐ Depression/Anxiety/Panic
☐ Back pain:
Degenerative/Stenosis/Herniation

☐ Back injury
☐ Neck injury
☐ Chronic headaches
☐ Other injury
☐ Fracture _____________
☐ TB/HIV/Hepatitis A, B, C
☐ Visual/Hearing Impaired
☐ Thyroid (type)
____

Other issues: ___________________________________

Surgical History

☐ Joint Replacement(s) *please explain:*____ *date:* _____________
☐ Orthopedic Surgery *please explain:*____ *date:* _____________
☐ Heart Surgery *please explain:*____ *date:* _____________
☐ Fracture Repair *please explain:*____ *date:* _____________
☐ Spinal Surgery *please explain:*____ *date:* _____________
☐ Other Surgeries *please explain:*____ *date:* _____________

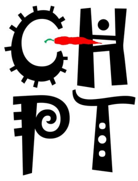
Please list your current medications: Name ☐ See attached list

Name	Dosage	Frequency

I understand that it is important for my therapist to understand my medical history in order to create a comprehensive treatment plan. I certify to the best of my ability, the above information is complete and accurate.

Patient/Guardian Signature ___________________________________ Date _______________________________

Patient Name ____ DOB ___ /___ /______



Patient & Billing Information

Patient Information

Name: Last_________________________________ First_____________________ Preferred _______________ MI ___

Gender ☐ M ☐ F Age_____ DOB___/___/______ Student: ☐ Yes: FT/ PT ☐ No

Marital Status: ☐ Married ☐ Single ☐ Other

(Optional) Gender Identity: ☐ M ☐ F Other ___________________ Pronouns: ______________________

Address____ City,State,Zip _________________________________

Phone Numbers: Cell ______________________ Home______________________ Work ______________________

Email ____ Preferred Phone ☐ Home ☐ Work ☐ Cell

Would you like appointment reminders by email? ☐Yes ☐No

Referring Physician ______________________________ Primary Care Physician_______________________________

Billing Information

Responsible Party: Last________________________________ First________________________________ MI ______

Phone Numbers: Home _______________________ Work ______________________ Mobile _____________________

DOB ___ /___ /______ Relationshipp to Patient____________________________

Address____ City, State, Zip ____________________________________

Is this Worker's Comp or an auto accident? ☐ YES ☐ NO Date of injury/accident ___ /___ /_____

Insurance Company ____ Case # ________________________________

Case Manager Name ___________________________ Phone ___________________ Fax _____________________

Employer _______________________________________ SS# _____________________ (needed to receive payment)

Employer Address ____ City, State, Zip _________________________

Insurance Information

Primary Insurance _______________________________

Subscriber Name ________________________________

Subscriber Date of Birth ___ /___ /______

Relationship to Patient _______________________

Insured Policy ID # ______________________________

Group Number _________________________________

Effective Dates __________________________________

Secondary Insurance ___________________________

Subscriber Name ________________________________

Subscriber Date of Birth ____ / ____ /______

Relationship to Patient _______________________

Insured Policy ID # ______________________________

Group Number _________________________________

Effective Dates __________________________________

Emergency Contact

Name: Last____________________ First___________________ Relationship to Patient _________________________
Address____ City, State, Zip ______________________________
Phone Numbers: Home _____________________ Work _____________________ Mobile ______________________

Release of Information

I authorize Callan-Harris Physical Therapy to provide my confidential health information to the following individuals:
Name: Last____________________ First___________________ Relationship to Patient _____________
Name: Last____________________ First___________________ Relationship to Patient _____________

Authorizations & Acknowledgements

☐ I hereby certify that the above information is complete and accurate according to the best of my knowledge and ability.

☐ I understand that the information provided above may be used and shared for the purposes of treatment, billing for services rendered, and conducting of administrative operations of Callan-Harris Physical Therapy per their **Notice of Privacy Practices** which I have had an opportunity to read, review, and receive. (They are available at the reception desk when requested)

☐ I give my consent to proceed with a therapy evaluation and corresponding treatment. I also give my consent that services may be observed and/or provided by a PT or PTA student under the supervision and instruction of a licensed physical therapist. Due to the nature of physical therapy and the physical exertion required to perform activities with increasing degrees of difficulty, I understand that there may be possible complications associated with my care such as an increase in my current level of pain, an aggravation of my existing injury, or very rarely, the development of a new injury. My signature below acts as a waiver of liability for treatment received at Callan-Harris Physical Therapy excepting acts of negligence.

Patient/Guardian Signature: ____ Date:_________________________

Patient Name (Print): ____ DOB ___ /___ /______

Financial Policy

If your visit is related to an automobile or personal injury accident, please notify the front desk.

☐ I understand it is my responsibility to understand my health insurance benefits, verify necessary referrals/authorizations are on file, and pay subsequent out of pocket expenses. I request and authorize my health insurance carrier to pay Callan-Harris Physical Therapy for all charges related to services provided to me. I understand that I am entirely financially responsible to Callan-Harris Physical Therapy for all services rendered and agree to pay in full any amounts not paid by an insurance company or other third party payer in addition to all co-payments, deductibles, or co-insurance which are due at time of service. All other payments are due 30 days after time of service. Should my account go to collections, I agree to pay all attorneys fees, court costs, filing fees, and all other charges that may be assessed.

We ask that you pay any outstanding balance at your visits to keep your account up to date. There will be a $5 charge for any bills that need to be mailed.

☐ **I understand that not showing for scheduled appointments will delay my plan of care, and that if I cannot attend one of my scheduled appointments, I must give a minimum of 24-hour notice when canceling. Failure to do so will result in a $40 fee for a no show or a cancel.**

☐ Callan-Harris Physical Therapy verifies insurance coverage and obtains a summary of insurance benefits for company purposes only. Although we may provide you with a copy of the benefits we were quoted, you are ultimately responsible for understanding your benefits. When we obtain a quote, we are given the following disclaimer: *This is an estimate of benefits only and in no way guarantees coverage or payment of claims*. If you have questions regarding your coverage, please call your insurance company.

☐ I understand that should my insurance benefits limit my physical therapy to a specific number of visits per year/condition, monetary amount, or require a referral or pre-authorization, it is MY responsibility to keep track of those numbers and verify with the front desk that the appropriate documents are on file. If I happen to go over my benefit limitations or neglect to verify authorizations/referrals are on file, I will be responsible for the entire balance on the exceeding visits or amounts.

☐ I understand that regardless of insurance, I am responsible for the cost of all services rendered at Callan-Harris Physical Therapy. Should my insurance company pay my claims at a different rate than was quoted to Callan-Harris Physical Therapy and listed above, I will honor the actual assignment of benefits. If I am not satisfied with the actual assignment of benefits, it will be my responsibility to contact my insurance company.

☐ I understand it is my responsibility to know which insurance is my primary carrier and which is my secondary. I recognize that Callan-Harris Physical Therapy relies on the information I provide to obtain my benefits information. I verify that I have provided them with the correct info at the time of my visit. Should there be changes, I will notify the office immediately.

Patient/Legal Guardian Signature ___________________________________ Date ________________

Patient Name (Print): ___________________________________ DOB ___ /___ /______