

P A T I E N T I N F O R M A T I O N

Name: _____ SS# _____ Driver's Lic#: _____
Address: _____ City: _____ St _____ Zip _____
Home Phone: _____ Wk. Phone _____ Cell: _____
Birthday: ____/____/____ Gender: M F Marital Status: M S W D Other
Occupation: _____ Employer: _____ Phone: (____) ____ - ____
Employer's Address: _____ City _____ State _____
Spouse's Name: _____ Employer: _____
Referring Physician: _____
Person Responsible for Account: _____ Phone: (____) ____ - ____
Responsible person's Birthday: _____ SS# _____
Insurance Co. to be billed: _____
Group or Policy #: _____ Name of Insured: _____
Secondary Ins. To be billed: _____
Claim, Group or Policy #: _____ Name of Insured: _____
Did your injury occur while at work? ____ If yes, when: _____
Emergency Contact Name: _____ Relation: _____
Day Phone (____) ____ - ____ Evening Phone (____) ____ - ____
How were you introduced to CORE Physical Therapy? _____
Email Address: _____

M E D I C A L H I S T O R Y

Please indicate (X) whether you have or had any of the following conditions:

<input type="checkbox"/> Heart Disease or Heart Attack	<input type="checkbox"/> Tumor or Cancer	<input type="checkbox"/> Respiratory Disease
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Kidney or Bladder Problems	<input type="checkbox"/> Asthma
<input type="checkbox"/> Stroke	<input type="checkbox"/> Anemia or Blood Disorder	<input type="checkbox"/> Epilepsy or Convulsions
<input type="checkbox"/> Hernia	<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Diabetes

If you have checked any of the above conditions, please explain. _____

Are you pregnant now? Yes No
Do you have any surgical implants (plastic, metal, etc.)? Yes No Explain: _____

Please list all previous surgical procedures with approximate dates. _____

Please list all medications you are currently taking. _____

Please list all allergies: _____

I have received Core Physical Therapy, Inc., Notice of Privacy Practices.

Patient Signature: _____ Date: ____/____/____

ASSIGNMENT OF BENEFITS & AUTHORIZATION TO RELEASE INFORMATION

NAME OF PATIENT: _____

NAME OF INSURED: _____

I hereby instruct and direct my insurance company to issue check(s) made out and mailed directly to: Core Physical Therapy, Inc. for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.**

FINANCIAL AGREEMENT

I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. As a courtesy, my insurance company will be billed. I agree to pay in a current manner and, in accordance with the terms and conditions of Core Physical Therapy, Inc. any balance to said professional fees over and above third party reimbursement, including deductibles, co-payments, exclusions or denials. I understand that if treatment is suspended or terminated, any fees for professional services rendered will be due and payable upon request. I understand that any payment which is delinquent (following 30 days from the request), may result in a 1.5% per month assessment on the remaining balance and that I will be fully responsible for any legal/collection or attorney fees, if it becomes necessary to resolve the outstanding balance. **A service charge of \$50 may be assessed for all no shows and cancellations within a 24-hour period.**

CONSENT FOR TREATMENT OF A MINOR

As parent and/or legal guardian, I authorize Dan Kinney or such other name as to be designated by Core Physical Therapy, Inc., to treat the minor patient as named above.

Signature of Parent/Guardian:

Date: _____

Print Name: _____

- *I further authorize the release of any pertinent information to my insurance company.*
- **MY CONDITION IS NOT A RESULT OF AN ACCIDENT OR WORK RELATED INJURY.**

Signature of Policyholder/Responsible Party:

Date: _____

Signature of Claimant/Responsible Party if other than Policyholder:

Date: _____

Witness:

Date: _____

PATIENT HEALTH INSURANCE POLICY

As a courtesy only, we will verify your Health Insurance benefits, however it is your responsibility to be knowledgeable of your physical therapy benefits, co-pays, deductibles, denials, and exclusions.

I have read and understand this policy _____ Date _____

PATIENT MISSED APPOINTMENT POLICY

We strive to provide our patients with the utmost professionalism and excellence of service. Our commitment to your well being and of your physical abilities is something everyone in our clinic takes quite seriously.

Because we care so much about you we realize that it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need to receive and to the actions we ask you to do.

Your adherence to the recommended number of treatments is a vital component of your progress with our services; therefore we have certain rules that need to be followed in order to ensure the most optimum results.

We expect you to keep all your appointments. Write down the time of your visits so that you do not forget.

With the exception of serious emergencies it is expected that you keep all of your appointments. If you need to reschedule an appointment we require a 24 hour notice. In such a case, please call our office and arrange for a make-up appointment with our Front Desk Receptionist. The make-up appointment needs to be in the same week, preferably the very next day.

In an instance of a **cancellation** without **24 hours** notice or a no-show to a scheduled appointment, we reserve the right to charge you a **\$50.00 fee**.

In instances of repeated non-compliance with your scheduled visits, we also reserve the right to discontinue care and will inform your physician of the fact that your service has been discontinued due to non-compliance with the prescribed rehabilitation order.

We appreciate you greatly as our patient and strive to accomplish wonderful results and success for you.

Dan Kinney
Core Physical Therapy, Inc.

I have read and understand this policy _____ Date _____