FORWARDPT

MOVEMENT SPECIALISTS FOR SENIORS

NAME ______________________________ MALE _____ FEMALE ______

ADDRESS ____________________________ CITY __________ STATE_____ ZIP________

SOCIAL SECURITY #______________________ DATE OF BIRTH ____/______/________

HOME # ________________________ CELL # ____________________________________

E-MAIL ____

PRIMARY CARE PHYSICIAN NAME _____________________ FAX #_________________

REFERRING PHYSICIAN (IF DIFFERENT THAN PCP)_________________________________

HOW DID YOU HEAR ABOUT US? ____

I hereby authorize direct payment of medical benefits to Forward Physical Therapy, PLLC for services rendered. I understand that I am financially responsible for any balance not covered by my insurance.

I hereby authorize Forward Physical Therapy, PLLC to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

A photocopy shall be valid as the original.

Patient / Guardian _______________________________________ Date ______________

(signature)

New patient History Form

Patient Name: ______________________________ Date:____ /____/____

Date of first MD visit for this injury:____ /____ /____ Next MD appointment?____/____/____

Gender: ❑M ❑F Birth Date: _____/_____/____ Hand dominance: ❑R ❑L

Briefly describe what brings you for therapy today:

____

____

Have you had any diagnostic tests performed? ❑ Yes ❑ No

If so, indicate which tests & approximate dates: ______________________________

Have you had surgery for this injury? ❑ Yes ❑ No Procedure(s) performed:

Most recent procedure/Date: Surgeon:

Please list any medical conditions you are aware you have (Please include anything you take medication for): ____

____

Pain

Do you have pain? ❑ Yes ❑ No

If yes, rate your pain on a scale from 0 (no pain) to 10 (excruciating pain) ______

Is your pain ❑constant or ❑intermittent? Does your pain wake you at night? ❑ Yes ❑ No Does your pain change based on your position? ❑ Yes ❑ No Is your pain worse in the AM or PM? ❑ Yes ❑ No If yes which is worse? ______________________________ Does your pain radiate from one place to another? ❑ Yes ❑ No If yes, Where? ______________________________

Orthopaedic History:

Please indicate any musculoskeletal or neurological problems/injuries/surgeries you have experienced in the past. Include those that occurred long ago even if they seem completely unrelated.____

____

Falls History

Have you fallen in the past 12 months? ❑ Yes ❑ No

If yes, please describe how you fell and any resulting injury:____

____

Are you or might you be pregnant? ❑ Yes ❑ No

Do you have a pacemaker? ❑ Yes ❑ No

What are your goals while in physical therapy?____

____

Name ______________________ Signature ________________ Date _____/_____/_____

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Consent for Treatment/Receipt of HIPAA Privacy Notice

All Patients Must Read and Sign the Following Before Treatment Can Commence

CONSENT FOR MEDICAL TREATMENT

I, the undersigned, am knowingly requesting medical services from Forward Physical and/or Forward Occupational Therapy. I am requesting these services willingly and voluntarily. I execute the same as my free and voluntary act for the purpose of receiving the healthcare services. I understand that my treating provider will be responsible for providing me with an explanation of current information regarding my diagnosis, treatment and prognosis and will require my consent on any procedures performed on me. My treating provider will ensure that I am adequately informed and understand the reasons for and indication of the procedure. I understand that I have the right to refuse such care, except in an emergency.

Printed Name of Patient/Guarantor on the Account **Date**

Signature of Patient/Guarantor on the Account **Date**

Relationship of Other than Parent **Date**

CONSENT FOR THE RELEASE OF MEDICAL INFORMATION

As the provider of healthcare services, we are hereby authorized to release any medical information required in treating you, for payment for services rendered to you or for other healthcare operations of Forward Physical and/or Forward Occupational Therapy. Before we release information to parties other than for treatment, payment, or for healthcare operations we will require a specific authorization from you.

I acknowledge that I have received The HIPAA Privacy Notice of Forward Physical and/or Forward Occupational Therapy. I have a right to restrict uses and disclosures of my health information as it pertains to treatment, payment and healthcare operations. If my restrictions are accepted, these restrictions will be binding. I also understand that Forward Physical and/or Forward Occupational Therapy is not required to agree to my requested restrictions. I do not request any restrictions or uses and disclosures of my health information for treatment, payment or healthcare operations at this time. I understand that I have a right to revoke this consent at any time in writing, but if I do, my revocation will not have an effect on any actions previously taken in reliance of this consent.

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

I authorize the release of any information necessary or helpful in processing claims for reimbursement for medical services. This authorization is valid for the release of medical information to all insurance carriers, and billing agents.

As signer below, I attest that Forward Physical and/or Forward Occupational Therapy has the right to maintain my signature on file for the purposes of filing claims. Additionally, my signature below will act as authorization for today's and future treatments, unless I rescind such authorization in writing.

I, the undersigned, acknowledge that I have been provided a copy of the HIPAA Privacy Notice of Forward Physical and/or Forward Occupational Therapy and my signature below attests to the receipt.

Printed Name of Patient/Guarantor on the Account **Date**

Signature of Patient/Guarantor on the Account **Date**

Relationship of Other than Parent **Date**

Cancellation and No Show Policy

It is important that all appointments are kept for the following reasons:

1. In order for you to get the most benefit from your therapy you need to follow the Plan of Care established with your therapist. This is your prescription for success, not just a suggestion.
2. When you don't attend your sessions as established in your plan of care, your insurance may deny payment
3. There are a limited number of appointments and once you schedule your appointment the time is no longer available for other patients
4. When appointments are cancelled at the last minute, or you don't show for your appointment, your therapist is here with no patient to see during that time.

For these reasons we have instituted a $50 late cancellation/No show fee.
We do NOT want to charge you a fee for not coming in. We would much rather you come to your appointments so we can help you achieve your goals!

How you can avoid this fee:

1. Attend your scheduled appointments!
2. Give us 24 hour notice for any appointment you need to cancel
3. If you need to cancel at the last minute you can reschedule your appointment for that same week so you keep to your plan of care. (If you are scheduled for twice a week, for example Monday and Wednesday, and you need to cancel Wednesday's appointment on short notice you can make up the visit on Thursday or Friday to avoid the fee.) If you cancel the "make-up" appointment you will be charged.

Please note, this fee will be collected before any follow up appointments are conducted.

Name ______________________________ Date ________________

Signature ______________________________

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Name: ______________________ Date: ____________

DOB: ______________________

Medication Profile

Medication	**Dosage**	**Method** (oral, injection, etc)	**X/day**