



PATIENT INFORMATION	
Name _____	SS# _____
LAST FIRST MIDDLE	
Birthdate _____	Marital Status _____ Sex _____ Phone _____
Address _____	City _____ State _____ Zip _____
Employment <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Unemployed <input type="checkbox"/> Self Employed <input type="checkbox"/> Retired (date) _____	
Employer _____	Occupation _____
Address _____	City _____ State _____ Zip _____
Work Phone _____	Extension _____

INSURANCE		
Primary Insurance _____	Insured/Member ID# _____	Group# _____
Secondary Insurance _____	Insured/Member ID# _____	Group# _____
GUARANTOR (NAME OF INSURED)		* If same as patient, please skip to next section
Relationship to patient _____	Name _____	
	LAST	FIRST MIDDLE
Birthdate _____	Home Phone _____	SS# _____
Address _____	City _____	State _____ Zip _____

PHYSICIAN / EMERGENCY CONTACT	
Referring Physician _____	
Primary Care / Family Physician _____	
Emergency Contact Name _____	Relationship to Patient _____
LAST FIRST MIDDLE	
Home Phone _____	Work Phone _____ Cell Phone _____

ACCIDENT INFORMATION	
Is this due to an Auto Accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Auto Accident Date and Time _____	State the Accident Occurred _____
Auto Insurance Info _____	Phone _____
Auto Insurance Address _____	City _____ State _____ Zip _____
Is this due to a Work-related injury? <input type="checkbox"/> Yes <input type="checkbox"/> No Work Injury Date and Time _____	
Case Manager/Adjustor Name _____	Phone _____

MEDICARE PATIENTS PLEASE COMPLETE THE FOLLOWING SECTION:		
Is your Medicare based on: <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> ESRD	YES	NO
Are you currently receiving any Home Health services from anyone?		
Have you had Physical Therapy services this year?		

NAME: _____

DATE: _____

INFORMATION ABOUT YOUR INJURY/PAIN

Complaint/Diagnosis _____ Onset Date _____
 Have you ever been treated for this injury? Yes No If so, what kind? _____
 Have you ever had Physical Therapy for this injury? Yes No
 Have you had x-ray/MRI/other imaging study for this problem? Yes No Results: _____

PAST MEDICAL HISTORY

Please check YES/NO if you presently have or have ever been diagnosed with any of the following:

	YES	NO		YES	NO
Pacemaker/Defibrillator			Osteoporosis		
Surgical Implants			Arthritis		
Cancer			Rheumatoid Arthritis		
Latex allergy			Asthma/Chronic Bronchitis		
High blood pressure			Emphysema		
Seizures			Hepatitis		
Diabetes			Bowel/Bladder Problems		
Low blood sugar			Head/Neck Trauma		
Stroke			Feel faint or have spells of severe dizziness?		
Pregnant (currently)			Have you fallen in the past 6 months?		
HIV/AIDS			Do you smoke?		
Lung disease			Alcoholism		
Any heart problems			Drug Abuse		

Are you receiving any treatment for any other medical condition: _____

PATIENT SUMMARY LIST

Significant Medical Diagnoses and Conditions: _____

Significant Infections(C-Diff, MRSA, etc): Yes No _____

Please list all Previous Surgeries (with approximate date) :

Do you take blood thinners/aspirin? Yes No

Medications & Dosages (including Prescriptions, Herbals and Over-the-Counters Drugs): See Attached Medication List



**- GENERAL AUTHORIZATION AND ATTENDANCE POLICY
ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES**

NAME:

DATE:

GENERAL AUTHORIZATION

ASSIGNMENT OF INSURANCE BENEFITS:

In consideration of services rendered, I hereby transfer and assign all right to payment due to me for physical therapy services under any policies of insurance to Wells Physical Therapy. As a courtesy, Wells PT will contact my insurance carrier for verification of my physical therapy benefits and will make every effort to discuss those benefits with the patient/responsible party in a timely manner. However, I understand that I am responsible for contacting my insurance carrier for determination of my physical therapy benefits and that I am responsible for payment of any services applied towards my co-payment, coinsurance, deductible and/or services not deemed medically necessary by my insurance carrier.

OPEN GYM ATMOSPHERE/CHILDREN:

I acknowledge that treatment may be provided in an open gym atmosphere. For the safety of our patients and your children, unattended small children are prohibited in the fitness/gym area and the reception area.

AUTHORIZATION FOR TREATMENT:

I hereby request and authorize all treatment from Wells Physical Therapy and/or associated assistants of their choice and understand my responsibility for payment of this account regardless of insurance.

RETURNED CHECK FEE & COLLECTION FEE:

There will be a \$30 charge for any check returned for insufficient funds. In addition, in the event of default, for any reason, the patient will be responsible for any and all fees associated with the collection process.

ATTENDANCE POLICY

There are many patients requiring our services; therefore, it is very important for each patient to keep his/her scheduled appointment times. Our goal is to deliver the highest level of quality of care, and to do so, our clinics need to provide continuous care.

CANCELING APPOINTMENTS

- If you must cancel an appointment, we ask that you please contact our office 24 hours in advance. If you do not call 24 hours in advance, you may be subjected to a \$30 cancellation fee. You may leave a message on our confidential voice mail if it is not during regular business hours.
- If we must change or cancel an appointment time with you, we will give you as much advance notice as possible. We appreciate your cooperation.

MISSED APPOINTMENTS

- If you miss a scheduled visit, your therapist or a staff member will attempt to call and remind you of your next scheduled appointment.
- If you miss up to three appointments during any 30-day period, your physician will be notified. Additionally, you will be required to return to your referring physician for a new prescription before returning to therapy as you will be discharged from therapy.

I have read the above and understand that my attendance and full participation in the program are necessary for my maximum recovery.

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have been offered a copy of this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed.

PATIENT'S NAME (PRINTED)

DATE

PATIENT'S SIGNATURE (OR GUARDIAN, IF A MINOR)

WITNESS (OPTIONAL)