

*****Please provide us with your insurance card(s) to photocopy.*****

Patient Data

First Name _____ Last Name _____
 Address _____ City _____ State ____ Zip _____
 Birthdate _____ Sex M / F Social Security # _____
 Home Phone _____ Work Phone _____
 Referring Physician _____ Date of Next Physician Appt _____
 Primary Physician _____

Employment Data

Patient's Employer _____
 Address _____ City _____ State ____ Zip _____
 Occupation _____
 Accident Information (Circle One) None Auto Work Other
 Date of Accident/Onset of symptoms _____ Injury Area _____

Insurance Data

Primary Insurance to be billed _____	Secondary Insurance to be billed _____
Phone # _____	Phone # _____
Group # _____	Group # _____
ID# _____	ID# _____
Relationship of Patient to Insured	Relationship of Patient to Insured
1Patient 2Spouse 3Child	1Patient 2Spouse 3Child
Name _____ Date of Birth _____	Name _____ Date of Birth _____

****If we are billing a worker compensation or auto insurance related to your treatment, it is your responsibility to obtain prior authorization from your private health insurance, if they require, in the event that your claim is denied.****

Do you have an attorney involved? Yes / No

If yes, his/her Name _____ Phone _____

Authorization to Pay Benefits and Release Information

*****I hereby assign Ability Physical Therapy & Fitness all payments to which I am entitled for expenses related to the services performed and direct that payment for such services be made to Ability Physical Therapy & Fitness. I authorize Ability Physical Therapy & Fitness to release such information as may be required to secure such payment. This agreement will remain in effect until revoked by me in writing. A photocopy of this document is to be considered as valid as an original.**

****If you are unable to keep your appointment, kindly call the office so the time reserved for you may be utilized.****

I understand I may be charged a \$25.00 fee for canceling my appointment with less than 24 hours notice.

I understand that if my insurance denies my claim I am responsible for full payment of all services rendered. I consent to Physical Therapy treatment. A fee of \$30.00 may be assigned if this account ages beyond 90 days.

Signed _____ Date _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES (To be retained by Medical Provider)

I understand that Ability Physical Therapy & Fitness_ (referred to below as “the clinic”) will use and disclose **health information** about me in the course of providing physical therapy care to me.

I understand that my **health information** may include information both created and received by the clinic, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar health-related information.

I understand that the clinic is permitted to **use and disclose** my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to/or consult and coordinate with other health care providers in the course of my treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support the clinic’s ability to provide me with appropriate care and arrange for payment.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices upon request and that a copy or a summary of the most current version of the clinic’s Notice of Privacy Practices in effect will be posted in waiting/reception area.

I understand that the Notice of Privacy Practices describes how I can exercise my right to ask that some or all of my health information not be used or disclosed, and I understand that the clinic is not required by law to agree to such requests.

By signing below, I agree that I have received or been offered a copy of this clinic’s Notice of Privacy Practices.

By: _____ Date: _____
(Patient)

-OR-

By: _____ Date: _____
(Patient representative)

Description of Representative’s Authority: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- * Individual refused to sign
- * Communication barriers prohibited obtaining the acknowledgment
- * An emergency situation prevented us from obtaining acknowledgement
- * Other (Please specify)

Ability Physical Therapy & Fitness

Name: _____ Age: _____ DOB: _____ Phone: _____
 Referred by: _____ Next Visit with Referring MD _____
 Primary Care Physician (if different then above) _____
 Emergency Contact: _____ Phone: _____
 Employment Unemployed Light duty Part Time Full Time Retired Student
 Dominant Hand Right Left Are you pregnant? Yes No
 Prescription Medications: _____
 Surgical History: _____

Medical History (circle all that you have ever had) **Are you having any of these symptoms**
 (circle all that apply)

Arthritis	Seizures	Chest Pain	Pain at night
Broken Bones/Fractures	Stroke	Coordination Problems	Weakness
Cancer	Head Injury	Difficulty Sleeping	
Diabetes	Multiple Sclerosis	Headaches	
Heart Problems	Muscular Dystrophy	Loss of balance	
High Blood Pressure	Parkinson's Disease	Visual Problems	
Lung Problems	Other: _____		
Osteoporosis			

History of current problem:

When did the problem(s) begin? _____
 What happened? _____
 Have you had this problem(s) before? Yes No
 What makes this problem(s) better? _____
 What makes this problem(s) worse? _____

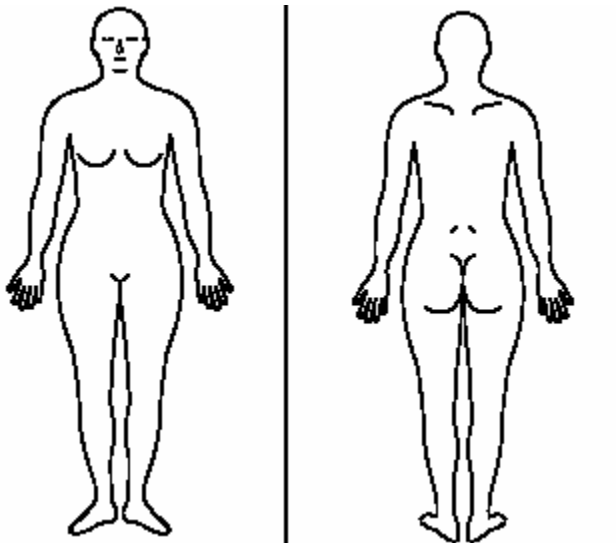
Please sketch the affected areas as follows:

Please rate your pain based

On this scale:

- 0-No pain
- 1-Very weak
- 2-Weak
- 3-Moderate
- 4-Somewhat strong
- 5-Strong
- 6-
- 7-Very strong
- 8-
- 9-Very, very strong
- 10-Emergency

NOW: _____
 Last 30 days: _____



I will advise the therapist if there are any changes in my physical condition that would alter my response to any of the questions on this form.

Patient Signature **Date**

 Reviewed by Therapist

Notice to Medicare Patients:

Medicare requires that you visit your referring physician at or before 90 days from the start of Physical Therapy. **If you fail to revisit your physician at or before 90 days and treatment continues past that they will not pay for Physical Therapy services in our office.** If you are continuing treatment with us past the 90 day mark, Medicare then requires that you recheck with your physician every 90 days thereafter.

Please let our staff know when your next appointment with your physician is.

**I understand that I must revisit my physician at least every 90 days for the first set of visits, then every 90 days thereafter or Medicare will deny payment for Physical Therapy Services. I will be personally liable for all charges incurred

Patient signature

Date

Our office would be glad to call to schedule your next appointment with your physician if you have not already done so.

Thank you.

*You MUST VISIT with your Referring Doctor
In their office every 90 days in order for Medicare
To process/pay you Physical Therapy Claims.
Your first date in the 90 day cycle begins on your
first visit with our office. Please ask for a Prescription
Slip to help expedite your Doctor visit.*

Thank you.

******Please inform our front desk of the date
Of each Doctor visit. ******

Ability Physical Therapy & Fitness
503/434 9594

Today's Date _____

Must Return to Dr. By _____