PLEASE PRINT AND CONFIRM ALL INFORMATION AND COMPLETE APPLICABLE SECTIONS

PATIENT INFORMATION

Patient Name _____ Referring Physician_____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Date of Birth _____ Sex _____ Primary Care Physician _____

Diagnosis _____

Email Address _____ Do you accept text reminders? (Y/N) _____

Emergency Contact _____ Phone _____

Have you had Physical Therapy Before? (Y/N) _____ Where? _____ When? _____

Insurance (Y/N) ____ How did you hear about us? _____ What time of day is best for appointments? _____

HEALTH INSURANCE INFORMATION

PRIMARY

Insurance Co. Name _____

ID # _____

Subscriber's Name (If other than self) _____

Subscriber's Date of Birth _____

Relationship to patient: Spouse ____ Parent ____ Other ____

SECONDARY

Insurance Co. Name _____

ID # _____

Subscriber's Name (If other than self) _____

Subscriber's Date of Birth _____

Relationship to patient: Spouse ____ Parent ____ Other____

WORKER'S COMPENSATION INFORMATION

Insurance Co. Name _____ Claim #_____

Adjustor _____ Phone _____ Ext _____

Employer at the time of Injury _____ Phone _____

Address _____ City _____State _____ Zip _____

Occupation _____ Employment status _____

Job Description/Daily Work Tasks (i.e. Lifting, carrying, reaching, etc.) _____

_____

_____

_____

_____

Patient Consent Agreement

The following are our office policies. ***Please read carefully*** *before signing, and be sure to ask questions you might have prior to signing this document.*

As a condition of my treatment by Atlas Physiotherapy I, _____, (Please print name) agree to the following:

1) I am responsible for understanding my own insurance coverage. I agree to contact my insurance carrier to find out if my treatment is covered and to take such steps as required to qualify my treatment for coverage. I agree to inform Atlas Physiotherapy of any changes to my insurance.
2) I agree to pay any received co-payment at every visit.
3) We request a 24 hour notice in the event of a cancellation. **If a patient cancels with less than 24 hour notice a fee of $25 is charged to them. Patients are charged for no-shows in the amount of $25**. Owner retains the right to discharge the patient if either behavior compromises the plan of care or access to services for other patients. Our intention is to develop a plan of care and schedule to help you get better in a timely fashion. If you are unable to follow your plan of care please have a discussion with your therapist.
4) If my check is returned to Atlas Physiotherapy for insufficient funds, I agree to pay applied bank charges in addition to the amount of the check.

Consent to Treat/Informed Consent

5) I authorize Atlas Physiotherapy to evaluate and treat my injury and perform any therapeutic procedure or treatment that is consistent with my diagnosis. I understand and am informed that, as in the practice of medicine, physical therapy may have some risks and my condition may worsen on rare occasions. No guarantee or promise has been made to me concerning the results of treatment. I understand that I can terminate any treatment at any time if I so desire.
6) I authorize Atlas Physiotherapy to release information relative to any outpatient physical therapy administered to any third-party payor(s) financially responsible for these services or to my referring and/or primary care physician.
7) I have read and understand the "Notice of Privacy Rights and Practices" (HIPAA) form.

Payment Guarantee

8) In consideration of the services rendered and to be rendered by Atlas Physiotherapy, I expressly guarantee payment of my account and agree to pay any charges left unpaid in whole or in part by my insurance carrier, and that I am ultimately responsible for account totals and balance regardless of the disposition of the insurance carrier.

Assignment of Benefits

9) I authorized payment directly to Atlas Physiotherapy for services rendered.
10) My insurance benefits were fully explained to me and I understand what they are. I understand that I am ultimately responsible for the cost of my treatments. If my insurance company refuses to pay, for any reason, for a service that I have received, I am responsible for the charges of those sessions.

_____ _____

Signature of Patient/Parent/Legal Guardian Date

PAST MEDICAL HISTORY QUESTIONNAIRE

Could you be or are you pregnant? YES NO

Do you now or have you ever had any of the following: (Please Check)

	YES	NO		YES	NO		YES	NO
Arthritis	_____	_____	Metal Implants	_____	_____	Osteoporosis	_____	_____
Cancer/Tumor	_____	_____	High Blood Pressure	_____	_____	Recent Weight Loss/Gain	_____	_____
Heart Disease	_____	_____	Current Infection(s)	_____	_____	Heart Attack	_____	_____
Tuberculosis	_____	_____	Pacemaker	_____	_____	Hepatitis	_____	_____
Vascular Disease	_____	_____	Thyroid Problem	_____	_____	Stroke	_____	_____
Headaches	_____	_____	Asthma	_____	_____	Head Injury/Concussion	_____	_____
Shortness of Breath	_____	_____	Hernia	_____	_____	Chronic Cough	_____	_____
Kidney/Bladder Problems	_____	_____	Fainting Spells	_____	_____	Previous Fractures	_____	_____
Diabetes	_____	_____	Previous Surgeries	_____	_____	Anemia	_____	_____
Hearing Loss	_____	_____	Sensitivity to Heat/Cold	_____	_____	Depression	_____	_____
Anxiety	_____	_____	Swelling in Ankles	_____	_____	Substance Abuse	_____	_____
Seizures/Epilepsy	_____	_____	Allergies	_____	_____	Deep Vein Thrombosis	_____	_____

Other, please explain_____

If you answered "YES" to any of the above, please explain and give approximate date (s):

_____

_____

Are you currently taking any medications? YES/NO **If "YES", please list on medications page.**

Have you received any other treatment for this condition at this time? (Physical Therapy, Chiropractor, Surgery, etc.). If YES, please list below.

_____

What are your goals for your Physical Therapy treatment?

_____

The information above is correct to the best of my knowledge.

_____ _____

Patient/Parent/Guardian Signature Date

Current Symptoms

Reason for your visit/chief compliant:

_____

_____

How would you describe your symptoms/pain?:

Sharp ☐ Dull ☐ Achy ☐ Stabbing ☐ Shooting ☐ Numbness/Tingling ☐ Other ☐:_____

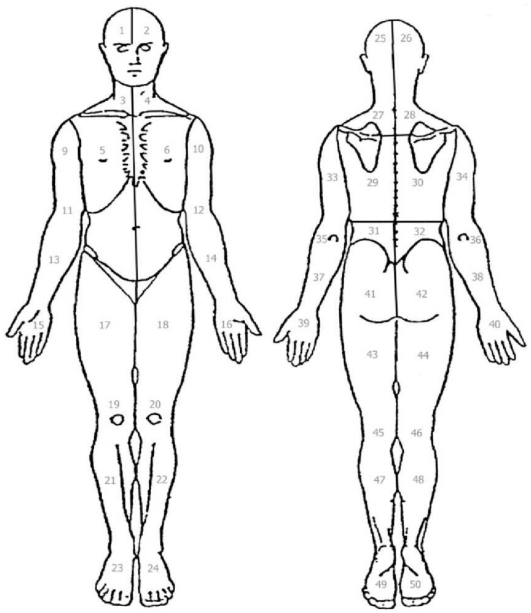
Frequency/Duration of Symptoms: **Are your symptoms getting:**

Constant ☐ Intermittent ☐ Activity Dependent ☐ Better ☐ Same ☐ Worse ☐

What aggravates your symptoms?: _____

What relieves your symptoms?: _____

Please mark the location of your symptoms/pain on the chart below:



Please circle your pain level CURRENTLY (0 = no pain and 10 = worst imaginable pain)

0 1 2 3 4 5 6 7 8 9 10

Please circle your pain level at its WORST in the past 24 hours (0 = no pain and 10 = worst imaginable pain)

0 1 2 3 4 5 6 7 8 9 10

Please circle your pain level at its BEST in the past 24 hours (0 = no pain and 10 = worst imaginable pain)

0 1 2 3 4 5 6 7 8 9 10

Medications List

Please list medications you are currently taking in the chart below:

Medication Name	Dosage	Frequency	Reason

The information above is correct to the best of my knowledge.

_____ _____

Patient/Parent/Guardian Signature Date