NEW PATIENT FORM

PLEASE PRINT CLEARLY

Date:__________________

Name (Last) _________________________ (First) ____________________________ (M.I.) ______

Birth Date____ Age ____________ Sex: M / F

Home Address____

City____________________________________ State__________ ZIP_________________________

Area to be treated______________________________ Injury Date ___________________________

Cell Phone (_____)____________ Home Phone (_____)___________Work Phone (______)____________

Email ____

How shall we contact you? (circle) Cell Ph. / Home Ph. / Work Ph. / Email

Status Married / Single / Divorced / Separated / Widowed **Student** No / Full-time / Part-time

Employment Full / Part-time / Not Working / Retired **Employer**____________________________

Emergency Contact__________________ Relation_________________ Phone________________

Referring Physician__________________________________ Telephone _____________________

How did you hear about us?
□ Friend/Relative _____________□ Internet □ Yelp □ Facebook □ Physician □ Other___________

Injury Type □ Work □ Auto □ Home □ Other_______________ Is an attorney involved? Yes / No

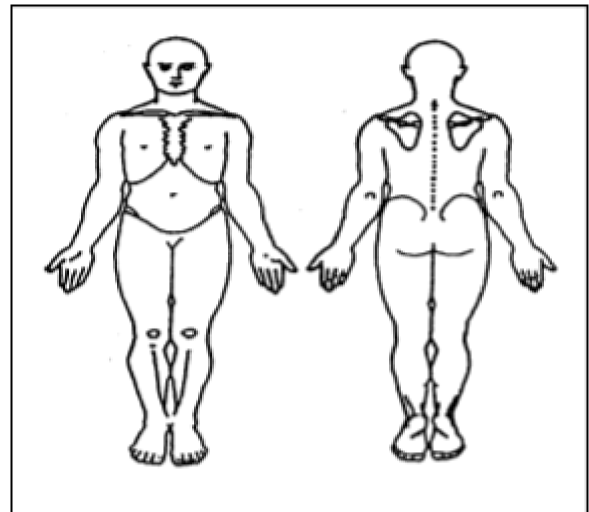
Patient Signature: ____**Date:** ________________

EMPOWER
PHYSICAL THERAPY & WELLNESS

MEDICAL HISTORY

Patient Name____
Age ____
Type of Injury / Condition ______________________________
Onset / Injury Date_____________________________________
Type of Surgery & Date _________________________________
Next Doctor's Appointment ______________________________
Describe previous treatment for this condition ____________
____

Please mark the area(s) of concern



Have you received physical therapy treatment this year? Yes / No
Have you received speech therapy treatment this year? Yes / No
Have you received Home Health Care via Medicare this year? Yes / No

Have you had any imaging performed? :

- ◻ X-Ray
- ◻ CT Scan
- ◻ MRI
- ◻ Doppler
- ◻ Ultrasound

Have you recently noted any of the following? :

- ◻ Weight Loss /Gain
- ◻ Nausea / Vomiting
- ◻ Fatigue
- ◻ Weakness
- ◻ Fever / Chills / Sweats
- ◻ Numbness / Tingling
- ◻ Pregnant / IUD
- ◻ Headaches
- ◻ Change In Vision or Hearing
- ◻ Pain at Night
- ◻ Cramps in Legs When Walking
- ◻ Insomnia

Do you have now or have you ever had any of the following? :

- ◻ Surgeries
- ◻ Loss of Consciousness
- ◻ Fractures
- ◻ Sprains / Strains
- ◻ Diabetes
- ◻ Blood Pressure Problems
- ◻ Heart Problems
- ◻ Cancer
- ◻ Motor Vehicle Accident
- ◻ Circulation Problems / Clots
- ◻ Asthma / Breathing Problems
- ◻ Lung Disease
- ◻ Easy Bruising / Bleeding
- ◻ Leg / Ankle Swelling
- ◻ Urinary Problems / Infections
- ◻ Indigestion / Heartburn
- ◻ Fainting
- ◻ Allergies / Skin Sensitivity
- ◻ Any previous injury that may affect current care

Please explain & give approximate dates for any items indicated above ______________________________
____

Are you currently taking medications? Yes / No Name or Type of Medication: ______________________
____

Type of Pain: Sharp / Burning / Aching / Tingling / Numbness / Other ______________________
Rate your pain: (1=minimal / 10=severe) At its **worst**: 1 2 3 4 5 6 7 8 9 10 At its **best**: 1 2 3 4 5 6 7 8 9 10
On a scale how important is it for you to get out of pain? (1=not important / 5=very important) 1 2 3 4 5
What do you hope to get out of your treatment? ____
____
What are your physical or fitness goals? : ____
____
Is there anything else you would like to include or ask your physical therapist? : ____________________
____

Patient Signature ____ **Date** ___________________

OFFICE POLICY

CONSENT FOR TREATMENT OF A MINOR: As parent and/or legal guardian, I authorize **Empower Physical Therapy and Wellness** to treat the minor patient named in the attached forms while I am not present.

CONSENT FOR CARE & TREATMENT: Your Physical Therapist will complete an evaluation by examination and interview. Your individual treatment program will then be designed. A variety of treatment techniques may be used. I the undersigned do hereby agree and give my consent for **Empower Physical Therapy and Wellness** to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize **Empower Physical Therapy and Wellness** to furnish information to insurance carriers concerning this treatment and I hereby assign all payment for services rendered.

WORKERS' COMPENSATION CLAIMS: If you claim Workers' Comp benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered.

CANCELLATION & NO-SHOW POLICY: We require 24 hours notice in the event of a cancellation. The charge for cancellation without proper notice is $50 for a physical therapy visit. This charge will not be covered by insurance, but will have to be paid by you personally, prior to receiving additional treatment.

Patient/Guardian/Responsible Party ______________________________ **Date** ___________

FINANCIAL POLICY: We bill your personal insurance carrier solely as a courtesy to you. You are responsible for your bill. Per the contractual obligations, we have with your insurance company, we are required to collect all payments at the time of treatment unless payment arrangements are made prior to your treatments. If your insurance carrier does not remit payment to us within 60 days, the balance owed will be due in full from you. In the event that your insurance company requests a refund of payments made to us, you may be responsible for the amount of money refunded to your insurance company. If any payment is made directly to you by the insurance company for services billed by us, you recognize an obligation to promptly remit the payment(s) to us. If formal collections procedures become necessary, you will be responsible for additional costs incurred. Your insurance benefits as quoted to us by your insurance carrier have been reviewed with you. We assume no liability for any errors made by your insurance carrier in this quotation. We have reviewed these benefits with you and you agree to pay your portion of this bill.

Patient/Guardian/Responsible Party ____________________________**Date**_______________

Clinic Representative____**Date**___________________

EMPOWER
PHYSICAL THERAPY & WELLNESS

24 HOUR CANCELLATION POLICY

To Our Patients Regarding Cancellations and No Shows:

When you do not attend as scheduled, three people are being hurt by the action: 1) you--because you did not receive your treatment as prescribed; 2) the therapist—who scheduled the time for you, and your treatment; 3) another patient who could have been scheduled if proper notice was given.

The following are our policies regarding cancellations and no-shows. We take this subject seriously at the clinic, because it can make the difference between whether or not you succeed in your treatment. You referring doctor or Therapist has prescribed a frequency of treatment and maintaining your scheduled visits is your highest priority.

- We require a 24-hour notice in the event of a cancellation. It is your responsibility, when you call, to have an alternate time in mind that will ensure you attend the entire number of prescribed treatments for each week.
- There is a $50 charge for a cancellation without proper notice. This charge is NOT covered by your insurance and will have to be paid by you personally. Even if it is a last minute cancelation, we greatly appreciate you notifying us so we can attempt to schedule our waiting list patients in your space.
- For worker's compensation and personal injury patients, documentation of any missed appointments will be forwarded to your Case Manager, and Primary Physician and this can jeopardize your claim.

In an instance of a cancellation without 24 hours notice, or No-Show to a scheduled appointment, we reserve the right to charge a $50 fee.

1. After the 1st offense a complimentary free wave reminder will be given.
2. After the 2nd offense there will be a fee of **$50** and will remain for all subsequent infractions.
3. Cancellation and No-Show fees are to be paid prior to the following appointment. You may not be able to be treated until fees are paid.
4. In addition, 3 offenses without payment may result in the loss of your physical therapy benefits. We reserve the right to cancel all future appointments and withhold scheduling future appointments.

______________________ **(Patient Initial)** ________________________**(Staff Initial)**

Please co-operate with our Cancellation and No-Show policy; it benefits all. We are looking forward to working with you!

______________________________________ ______________________________

Patient (Guardian) Signature: **Date:**

EMPOWER
PHYSICAL THERAPY & WELLNESS

HIPAA POLICY

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR THE PURPOSES SET FORTH WITHIN THIS AUTHORIZATION

Signature of Patient/ Representative ________________________**Date** _______________

Patient's Name (Print) ____

Date of Birth _____________________________

Name of Personal Representative (if applicable) ____

Relationship to Patient ____

A copy of the completed and signed Authorization form has been provided to the patient or representative: Yes ______ No_______

Signature of Authorized Clinic Representative _____________________________Date__________