EMPOWER
PHYSICAL THERAPY & WELLNESS

NEW PATIENT FORMS

PLEASE PRINT CLEARLY

Date: _____

Name (Last) _____ (First) _____ (M.I.) _____

Date of Birth _____ **Sex** (circle) M / F / Prefer not to say

Home Address _____

City _____ **State** _____ **ZIP** _____

Cell Phone _____ **Home Phone** _____

Email _____

Preferred form of contact? (circle) Cell Ph. / Home Ph. / Email

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

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

Emergency Contact _____ Relation _____

Emergency Contact Phone _____

Referring Physician _____ Telephone _____

How did you hear about us?

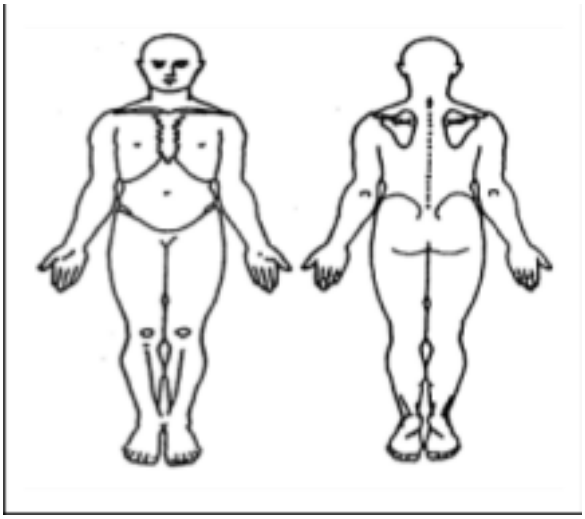
☐ Friend/Relative _____ ☐ Website ☐ Google ☐ Facebook ☐ Physician ☐ Other _____

Injury Type ☐ Work ☐ Auto ☐ Home ☐ Other _____ Is an attorney involved? Yes / No

Patient/Guardian/Responsible Party Signature _____ **Date** _____

MEDICAL HISTORY

Please mark the area(s) of concern



Patient Name _____

Age _____

Type of Injury / Condition _____

Onset / Injury Date _____

Type of Surgery & Date _____

Next Doctor's Appointment _____

Describe previous treatment for this condition _____

Have you received physical 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 ☐ 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

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.

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.

Patient/Guardian/Responsible Party Signature _____ **Date** _____

OFFICE POLICIES

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.

NOTICE OF CHANGE IN INSURANCE: It is the responsibility of the patient to notify Empower Physical Therapy and Wellness of any changes in insurance carrier/coverage as soon as possible. The patient will be responsible for any denied claims due to change/lapse in insurance coverage.

Patient/Guardian/Responsible Party _____ **Date** _____

(If applicable) 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.

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.**

Patient/Guardian/Responsible Party _____ **Date** _____

PRIVACY POLICY: I hereby authorize the release of my patient health care information for the purposes of treatment or payment, to my physician, insurance company, adjustor, attorney, or other health care organizations pertinent to my case. Further, I authorize Empower Physical Therapy to obtain needed information from my physician, insurance company, adjustor, attorney and any other health care organization pertinent to my case. These correspondence can be made via mailings, telephone and/or facsimile.

Patient/Guardian/Responsible Party _____ **Date** _____

24 HOUR CANCELLATION POLICY

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.

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.

If a 24 hour notice is not provided, or you No-Show to a scheduled appointment, we reserve the right to charge a $65 fee.

1. After the 1st offense, we will wave the fee one time as a courtesy to you

2. After the 2nd offense, there will be a fee of **$65** (not covered by insurance) 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, 2 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.

LATE ARRIVAL POLICY

To ensure the highest quality of service and respect for all clients' time, we have established the following policy regarding late arrivals:

1. Please arrive on time. Being on time helps us stay on schedule and give you the best service possible.

2. 10-minute grace period. If you're up to 10 minutes late, we'll still do our best to see you without cutting your time short.

3. More than 10 minutes late. If you're more than 10 minutes late, your appointment will be rescheduled and you may be charged a no-show or late fee.

4. Let us know. If you're running late, please call us. We'll try to work with you if we can.

5. Repeated lateness. If it happens often, we may need to change how we schedule your visits.

Thank you for helping us stay on track and respect everyone's time.

Patient/Guardian/Responsible Party _____ **Date** _____