

# Patient Information

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone-Home: ( ) \_\_\_\_\_ - \_\_\_\_\_ Work: ( ) \_\_\_\_\_ - \_\_\_\_\_ Mobile: ( ) \_\_\_\_\_ - \_\_\_\_\_

Social Security No.: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ (Circle) Male/ Female

Referring Physician: \_\_\_\_\_

Employer/School: \_\_\_\_\_

Occupation/Sport: \_\_\_\_\_ E-mail: \_\_\_\_\_

SPOUSE OR PARENT/GUARDIAN:  N/A

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Business Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

Date of Injury/Onset of Pain: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Surgery for this Condition: \_\_\_\_/\_\_\_\_/\_\_\_\_ or N/A

Injury is due to: 1. Accident (Auto/Other), 2. Illness, 3. Work, 4. Other \_\_\_\_\_

Is this a Work Comp. Injury? YES/ NO Are you currently Working? YES/NO

Area(s) of pain and area(s) to be treated: \_\_\_\_\_

IN CASE OF AN EMERGENCY, WHOM MAY WE CONTACT?

Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

INSURANCE INFORMATION:

Have you provided Head 2 Toe PT with your primary health insurance information? Yes- No- N/A

Have you provided Head 2 Toe PT with your secondary health insurance information? Yes-No-N/A

*How did you hear about Head 2 Toe PT?* Circle (Physician, Physician Staff, Phone Book, Internet, Family Member, Previously Patient, Insurance Company)

## **Consent to Treatment**

I give consent for Head 2 Toe Physical Therapy to treat my condition within the scope of practice defined by the American Physical Therapy Association Practice Act and the Licensing Board of the Department of Consumer Affairs. Treatment is administered based on the physician's diagnosis and requires a prescription throughout the plan of care. It is my responsibility to provide Head 2 Toe Physical Therapy with these prescriptions as needed. I also understand that if I wish to stop treatment at any time for any reason, I must simply tell my therapist to stop or adjust treatment to my preference.

## **Assignment of Benefits**

I hereby authorize, Head 2 Toe Physical Therapy Inc. to furnish to my insurance carrier(s) any and all requested information concerning my health care. I also authorize my insurance carrier(s) to pay Head 2 Toe Physical Therapy Inc. directly for services rendered.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

# General Health Questionnaire

Do you currently experience any of these symptoms?

- |   |       |     |       |    |
|---|-------|-----|-------|----|
| 1. Fevers/Chills/sweats                               | _____ | Yes | _____ | No |
| 2. Unexplained weight loss/gain                       | _____ | Yes | _____ | No |
| 3. Malaise (feeling generally unwell)                 | _____ | Yes | _____ | No |
| 4. Unusual fatigue                                    | _____ | Yes | _____ | No |
| 5. Nausea/Vomiting                                    | _____ | Yes | _____ | No |
| 6. Numbness/tingling                                  | _____ | Yes | _____ | No |
| 7. Weakness   | _____ | Yes | _____ | No |
| 8. Dizziness/lightheadedness/loss of consciousness    | _____ | Yes | _____ | No |
| 9. Chest pain/palpitations                            | _____ | Yes | _____ | No |
| 10. Swelling in feet or hands                         | _____ | Yes | _____ | No |
| 11. Difficulty breathing/shortness of breath          | _____ | Yes | _____ | No |
| 12. Difficulty breathing when lying down              | _____ | Yes | _____ | No |
| 13. Cough/change in cough/blood in phlegm             | _____ | Yes | _____ | No |
| 14. Wheezing  | _____ | Yes | _____ | No |
| 15. Difficulty with swallowing                        | _____ | Yes | _____ | No |
| 16. Heartburn/Indigestion                             | _____ | Yes | _____ | No |
| 17. Change in appetite                                | _____ | Yes | _____ | No |
| 18. Specific food intolerance/nausea/vomiting         | _____ | Yes | _____ | No |
| 19. Bowel pattern changes (color, texture, frequency) | _____ | Yes | _____ | No |
| 20. Difficulty urinating (starting/stopping)          | _____ | Yes | _____ | No |
| 21. Urine frequency changes                           | _____ | Yes | _____ | No |

History of :

- |                     |                    |
|---------------------|--------------------|
| Cancer              | _____              |
| Diabetes            | _____              |
| Osteoarthritis      | _____              |
| High Blood Pressure | _____              |
| Rheumatoid Arth.    | _____              |
| Heart Disease       | _____              |
| Stroke              | _____              |
| Osteoporosis        | _____              |
| Smoking             | Yes _____ No _____ |

Women Only: Pregnant ?  
Yes \_\_\_\_\_ No \_\_\_\_\_

Please list medications you are currently taking: \_\_\_\_\_

Are you allergic to any medications (cortisone?) \_\_\_\_\_

What medical conditions exist in your parents' (birth mother and father) medical history? \_\_\_\_\_

### Circle your Current Pain

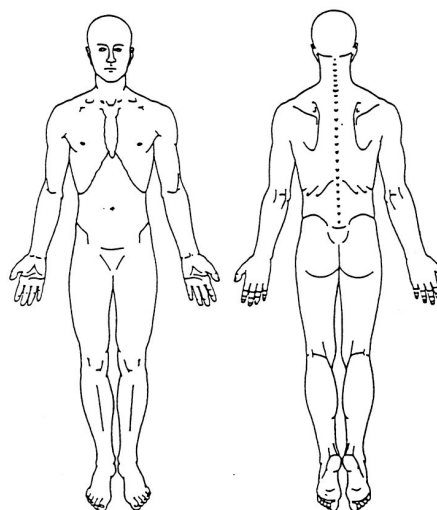
No Pain 1 2 3 4 5 6 7 8 9 10 Max Pain

**Are your symptoms (circle):**

Getting Worse / Same / Improving?

**Please indicate on the diagram to the right your current symptoms:**

Burning=XX; Pins & Needles=00; Stabbing=//; Deep Ache=ZZ



Print Your Name: \_\_\_\_\_

1-7 General/8-13 CV/11-14 PS/15-18 GI (upper back/shd)/19 GI (low back)/20-21 UG

We are committed to providing you with the best possible care. In order to achieve this goal, we need your assistance and your understanding of our payment policies.

**ALL PAYMENTS ARE DUE AT THE TIME OF SERVICE. WE BILL YOUR INSURANCE AS A COURTESY FOR YOU ON YOUR BEHALF.**

### **Private Health Insurance**

If you have a co-payment, it is **DUE** at the time of treatment. We will bill your insurance company. For non-participating insurances, services will be at the reasonable and customary rates. Should you have any questions, we will gladly help you; however, it is your responsibility to know and verify benefits from your insurance company.

\_\_\_\_\_(Initial) **I understand that my insurance company will make final determination of payment for services and may be different than benefits verified before my initial evaluation.**

### **Medicare**

We will bill Medicare for you and will also bill your secondary insurance carrier, if applicable. Medicare pays approximately 80% of the allowed amount and the secondary usually pays the other 20%. There are limits for services that Medicare pays. You will be billed directly for any supplies. If payment is sent to you personally and not our office, you are responsible for any and all portions up to the allowed amount.

### **Workers Compensation**

You will be immediately responsible for therapy costs if your workers compensation carrier denies the claim for any reason. Your case manager will be notified of any missing appointments, and may jeopardize your claim. Please contact the office should you need to reschedule your appointment.

\_\_\_\_\_(Initial) **Head 2 Toe PT reserves the right to discontinue treatment if you fail to comply with the policies above. Any returned check for insufficient funds will be assessed a \$50.00 processing fee.**

\_\_\_\_\_(Initial) **Twenty Four (24 Hour) notification is requested when cancelling an appointment. I understand that if I cancel/No show an appointment within 24 hours and another patient cannot use my appointment slot, I will be personally charged a \$50.00 late cancel fee.**

\_\_\_\_\_(Initial) **I have received the Notice of Privacy Practices (HIPPA) and I have been provided an opportunity to review it.**

I have read, understand, and agree to the above financial and clinic policies.

Name: \_\_\_\_\_ (print) Signature: \_\_\_\_\_ Date: \_\_\_\_\_