PRO ACTIVE
PHYSICAL THERAPY

ADMISSION FORM

:MR Number:

PATIENT INFORMATION

Patient Name: _____ Date Injured: _____ _____

Address: _____ SS#: _____ _____

City: _____ State: _____Zip: _____ Date of Birth: _____ Sex: _M _F

Home Ph#:_____Work Ph#:_____ Cell Ph#: _____

Employer Name: _____

Employer Address: _____ Workers Comp: _Y _N

City: _____ State: _____Zip: _____ __ Auto Accident: _Y _N

Have you received physical therapy at other locations this year? _Y _N

If so, how many visits have you had? _____

PERSON WHO SIGNS CONSENT AND IS RESPONSIBLE FOR BILL _____ SELF

Insured (Responsible) Party Name: _____ Relationship to Patient: _____

Address: _____ Date of Birth: _____/ __ / _____ SS#: _____

City: _____ State: _____ Zip: _____

Home Ph#: _____Work Ph#: _____ Employer Name: _____

PHYSICIAN INFORMATION

Referring MD: _____ Phone #: _____Primary Care MD: _____ Return to MD: _____ _

INSURANCE INFORMATION

If you are being seen for an injury related to work comp or an automobile accident, please give us the name of *your workers compensation/automobile carrier instead* of *you primary personal medical insurance carrier.*

Primary Insurance: _____ ID#: _____ Group #: _____ Ph#: _____

Pt. Relationship to insured: _Self _Spouse _Child _Other

Do you have Secondary Insurance? _____ Yes _____No If so Insurance Name: _____ _

Adjuster: _____Claim #:, _____ _____Is your case in litigation? _Yes _No

Attorney's Name: _____ _____ _

How did you hear about ProActive Physical Therapy? Friend/Relative? If so, who? _____ Physician: _____

Insurance: Employee: Yellow Pages: __ Website: Other: _____

I authorize the release of any private health information necessary to process this claim.

I, the undersigned, agree whether signing as agent or as patient, that in consideration of the services rendered to the patient, to be individually obligated to pay the bill. Should the account be referred to an attorney for collection, I shall pay reasonable attorney's fees.

I hereby assign payment directly to ProActive Physical Therapy, BASIC BENEFITS and/or MAJOR MEDICAL (catastrophe) BENEFITS herein specified and otherwise payable to me, but not to exceed the regular charges for this period of treatment. I understand I am financially responsible for any charges not covered by this assignment.

I understand that upon discharge I may request, in writing, a copy of my records.

I have read, understand and signed the ProActive Physical Therapy Financial Policy

Signed: _____ Dated: _____

_____ Insured and/or Responsible Party

Consent for Treatment

I hereby consent to such treatment procedures and patient care which, in the judgment of my therapist and/or physician, may be considered necessary or advisable while a patient at ProActive Physical Therapy, P.C. I also understand that ProActive Physical Therapy, P.C. may use my patient treatment data for quality assurance and research purposes, and that my name or identity will not be connected with the data.

Signed:_____ Dated: _____

Insured and/or Responsible Party

ADMISSION FORM
OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our *Financial Policy* that we require you to read and sign prior to any treatment.

All patients must complete out *Information and Insurance Form* before seeing the therapist.

REGARDING INSURANCE

We will gladly bill your insurance company directly if you have provided us with all the necessary information to do so on a bi-weekly basis. Your contract for health insurance is between you and your insurance company. We are not a party to that contract. The physical therapy services that you receive and the bill, is an agreement between you and ProActive Physical Therapy. It is ultimately your responsibility to see that your physical therapy bill is paid in full. Agreements with the insurance companies vary greatly and it is your responsibility to know what their portion is and what is yours. Any remaining money unpaid by your insurance company will be your responsibility to pay in a timely manner. If your insurance company does not begin paying ProActive Physical Therapy within 5 weeks, it will be your responsibility to contact them. You will be notified by mail of the balance due on your account, and you may request a statement of account if necessary. It will reflect what you insurance company, upon verification, told us is your portion to pay. We expect this payment within 15 days. If payment is not received within this 15-day period, a finance charge of 1.5 % will be assessed per month. In the event a check is returned for any reason, a $20.00 charge will be made to your account.

REGARDING INSURANCE PLANS WHERE WE ARE A PARTICIPATING PROVIDER

All co-pays and deductibles are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to the above paragraph.

If you receive payment made out to both ProActive Physical Therapy and you, please endorse the check and forward to us.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurances.

ADULT AND MINOR PATIENTS

Adult patients are responsible for full payment at the time of service. The parents (or guardians) accompanying a minor are responsible for full payment of the minor's treatment. For unaccompanied minors, non-emergency treatment will be denied unless charges are paid by cash or check at the time of service.

MISSED APPOINTMENTS

Because we commonly have a waiting list, unless cancelled at least 8 hours in advance, our policy is to charge for missed appointments. The charge is $25.00 for the first missed appointment and $50.00 for the second missed appointment and $75.00 for each subsequent missed appointment. Insurance does not pay this charge. You are responsible. Please help us serve you better by keeping scheduled appointments, or call us to cancel, in a timely manner to allow another patient to have your scheduled time.

I have read the *Financial Policy.* I understand and agree to this *Financial Policy.*

HIPAA

I acknowledge the receipt of ProActive Physical Therapy's *HIPAA NOTICE OF PRIVACY PRACTICES.*

Signed: _____ Dated: _____

Is there anyone involved in your care, or payment of your care with which we may share your medical information?

__Yes __No If yes, person's name: _____ Relationship: _____

PATIENT CANCELLATION AND "NO SHOW" POLICY

Your scheduled appointment is a *specific time when your therapist will spend time with you. It is extremely important to be timely.*

FOR PHYSICAL THERAPY SERVICES

If you are unable to attend, YOU MUST NOTIFY THE CLINIC AT LEAST 8 HOURS IN ADVANCE AND RESCHEDULE TO MAKE UP THE MISSED APPOINTMENT. Failure to attend your sessions may hinder your recovery process as well as disrupt the schedule of your therapist.

Cancellation or failure to attend three consecutive appointments will result in termination of your therapy program. To restart your therapy you must return to your physician for a new prescription and obtain additional authorization from your insurance company.

Workers' Compensation Patients

In the event that you are covered by workers' compensation and fail to keep the appointments as recommended by your physician, the appropriate parties WILL BE NOTIFIED OF YOUR ABSENCE IN WRITING. Typically, the notification will be to your physician, insurance carrier, and employer and rehabilitation consultant. Each cancelled and "no show" appointment will also be noted in your chart. Please understand that failure to actively participate in your rehabilitation program may result in the impression that you are disinterested in your recovery or are better and able to return to work. Failure to attend therapy may have a negative effect on your workers' compensation coverage.

FEES

- The first time you miss your appointment, you will be charged a fee of $25.00.
- The second time you fail to call and cancel an appointment you will be charged a fee of $50.00.
- The third time you fail to keep your appointment you will be charged a fee of $75.00.

WE THANK YOU FOR RESPECTING THIS POLICY.

I, the undersigned, understand the *Patient Cancellation and No show Policy described above.*

_____ _____

Patient Signature Date

_____ _____

Therapist Signature Date

PRO ACTIVE
PHYSICAL THERAPY

MEDICAL HISTORY/SUBJECTIVE INFORMATION

A complete medical history is necessary for a thorough evaluation. Please answer the following questions.

Your Name:				**Today's Date:**
Date of Birth:	**Age:**	**Height:**	**Weight:**	**Do You Smoke?** ☐ **Yes** ☐ **No**
Sex: ☐ **Male** ☐ **Female** **If female,** are you currently pregnant? ☐ **No** ☐ **Yes** **If yes,** ☐ 1st Trimester ☐ 2nd Trimester ☐ 3rd Trimester				

Have you ever been diagnosed with any of the following?

Tuberculosis	☐ No	☐ Yes	Cancer	☐ No	☐ Yes	Arthritis	☐ No	☐ Yes
Diabetes	☐ No	☐ Yes	Hepatitis	☐ No	☐ Yes	Stroke	☐ No	☐ Yes
Heart Condition	☐ No	☐ Yes	Epilepsy	☐ No	☐ Yes	Respiratory Problems	☐ No	☐ Yes

Other: _____

Who referred you to physical therapy? _____

Primary Physician _____

Tell Us About Your Condition

When did you first notice the pain or have functional problems due to the condition/injury? (Please provide approximate dates): _____

Recent flare-up? ☐ No ☐ Yes If yes, when _____

What activities are limited by this condition? (e.g. lift, reach): _____

How did your injury/symptoms occur? _____

_____

What do you expect to accomplish with physical therapy? _____

Are your symptoms: ☐ Constant? ☐ Intermittent? ☐ Getting Better?
☐ Getting worse? ☐ Staying the same?

What makes your symptoms better? _____

0-10 pain scale (0 = No Pain; 5= Moderate Pain; 10 = The Most Extreme Pain)

Worst pain rating: 0 1 2 3 4 5 6 7 8 9 10

Best pain rating: 0 1 2 3 4 5 6 7 8 9 10

For this injury, has your medical care included: (check those that apply)

☐ Surgery: When? ___/___/___ What kind?_____

☐ Injection: When? ___/___/___ Did it help? ☐ Yes ☐ No

☐ Other treatment:

☐ Physical therapy If yes, when? ___/___/___to ___/___/__
What was done?_____

☐ Chiropractor If yes, when? ___/___/___to ___/___/___
What was done? _____

☐ Medications: _____

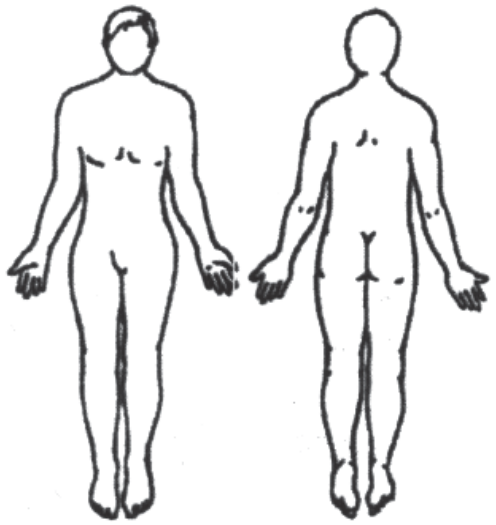
☐ X-ray _____ ☐ MRI _____

☐ CT scan _____ ☐ Other: _____

☐ Exercises: What kind? _____

Indicate on body diagrams **where** your symptoms are located

■ = Pain ***///*** = Numbness



Comments:_____

_____

_____

Indicate either "Yes" or " No" as to whether each of the following activities is difficult.

Drinking or Eating	_ Yes _ No	Balancing on both feet	_ Yes _ No
Sleeping Through the Night	_ Yes _ No	Walking on: stairs, flat surfaces, inclines, uneven surfaces, ladders	_ Yes _ No
Dressing: Putting on or taking off shoes, socks, shirt, jacket or pants	_ Yes _ No	Lifting	_ Yes _ No
Maintaining static position of; Head bent forward, arms overhead, arms forward, or turning head	_ Yes _ No	Carrying	_ Yes _ No
Getting in/out of: chairs, bed, car or bath/shower	_ Yes _ No	Bending, Kneeling Squatting	_ Yes _ No
Reaching: overhead, behind back, downward for forward	_ Yes _ No	Driving a vehicle or ability to use gas/brake pedals	_ Yes _ No
Gripping, Holding tools or Opening Jars	_ Yes _ No	Caring for child or adult	_ Yes _ No
Picking up Small Objects	_ Yes _ No	Housework / Yard work	_ Yes _ No
Sitting	_ Yes _ No	Recreational Activities	_ Yes _ No
Standing	_ Yes _ No	Have you fallen more than 1 time in the past year	_ Yes _ No
Job Related Activities	_ Yes _ No	Have you fallen and hurt yourself in the past year	_ Yes _ No

Other:

PRO ACTIVE
PHYSICAL THERAPY

CURRENT MEDICATIONS LIST REPORT

PATIENT NAME: **DATE:**

LIST ALL THE PRESCRIPTION MEDICATIONS YOUR ARE CURRENTLY TAKING			
NAME OF THE MEDICATION	**DOSAGE** (how many or how much you take)	**FREQUENCY** (how often do you take it)	**ROUTE** (how do you take it, i.e., by mouth, injection etc.)

LIST ALL OVER-THE -COUNTER MEDICATIONS			
NAME OF THE MEDICATION	**DOSAGE** (how many or how much you take)	**FREQUENCY** (how often do you take it)	**ROUTE** (how do you take it, i.e., by mouth, injection etc.)

LIST ALL HERBALS, VITAMINS, MINERALS, NUTRITIONAL SUPPLEMENTS			
NAME OF THE MEDICATION	**DOSAGE** (how many or how much you take)	**FREQUENCY** (how often do you take it)	**ROUTE** (how do you take it, i.e., by mouth, injection etc.)