THERAPIST ______________________ DATE/TIME ______________________

WELCOME TO OUR CLINIC

PLEASE PRINT AND CONFIRM ALL INFORMATION AND COMPLETE APPLICABLE SECTIONS

PATIENT INFORMATION

Patient Name______________________ Referring Physican______________________

Address______________________ City______________________ State_______ Zip ___________

Home Phone______________________ Cell______________________ Primary Physician ______________________

Date of Birth ______________ SS# ______________ Sex_______ Diagnosis ______________________

Employer ______________________ Address ______________________

City ______________________ State _______ Zip__________ Phone ______________________

Emergency Contact ______________________ Phone ______________________

Injury Result of Accident? Y or N Work Comp? _______ Auto? ______ Date of Injury ______________________

Have you had Physical Therapy Before? _________ Where? ___________ When? ___________ Insurance ______________

HEALTH INSURANCE INFORMATION

PRIMARY SECONDARY

Insurance Co. Name______________________ Insurance Co. Name ______________________

Address ______________________ Address ______________________

City ______________ State ______ Zip _________ City ______________State ______ Zip ________

Phone # ______________ Group # ______________ Phone # ______________ Group # ______________

ID # ______________________ ID # ______________________

Subscriber (If other than patient) Date of Birth ___________ Subscriber (If other than patient) Date of Birth ___________

Name ______________________ Name ______________________

Relationship to patient Spouse _____ Parent ____ Other ____ Relationship to patient Spouse _____ Parent ____ Other ____

Copay/Coinsurance ______________________ Benefit ______________________

WORKMANS COMPENSATION INFORMATION

Insurance Co. Name ______________________ Claim # ______________________

Address ______________________ City ______________________ State _________ Zip ___________

Adjustor ______________________ Phone ______________________ Ext ______________

Employer at the time of Injury ______________________ Phone ______________________

Address ______________________ City ______________________ State _________ Zip ___________

UR Phone ______________________ UR Fax ______________________

AUTOMOBILE INSURANCE INFORMATION

Insurance Co. Name ______________________ Claim # ______________________

Address ______________________ City ______________________ State _________ Zip ___________

Adjustor ______________________ Phone ______________________ Ext ______________

Name of Insured (If other than patient) ______________________ Relationship ______________________

PIP Available? ______________________

FURNACE BROOK PHYSICAL THERAPY PATIENT 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 Furnace Brook Physical Therapy ("FBPT") 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 FBPT of any changes to my insurance.
2) If FBPT does not receive insurance authorization for my treatment, I understand that I may sign an insurance waiver, which is valid for one treatment session.
3) I agree to pay any received co-payment at every visit, or in advance.
4) I will pay for any non-covered medical supplies (ie. Theratubing, Ionto pads) at the time of the disbursement.
5) We request a 24 hour notice in the event of cancellation. I understand that treatment might be terminated if I cancel or no show for 3 appointments without rescheduling. *We only treat patients who help us get them well.*
6) If my check is returned to FBPT for insufficient funds, I agree to pay applied bank charges in addition to the amount of the check.

Consent to Treat/Informed Consent

7) I authorize FBPT to evaluate and treat my injury and perform any therapeutic procedure or treatment that is consistent with my diagnosis. I authorize FBPT (including students in training) to administer treatment under the direction and supervision of the physical therapy. I will be given the opportunity to ask questions regarding my treatment, if they so arise, and that my physical therapist will be available to answer my questions. 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.

Payment Guarantee

8) In consideration of the services rendered and to be rendered by FBPT, 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 Furnace Brook Physical Therapy for services rendered.

____ ____________________

Signature of Patient/Parent/Legal Guardian Date

PAST MEDICAL HISTORY QUESTIONAIRE

Patient Name ____

DOB: ______________________ Date of Injury/Onset _______________________________

Have you ever received therapy before? YES NO

If so, when? ____

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
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	_____	_____
Hypersensitivity			Depression	_____	_____
To Heat/Cold	_____	_____	Anxiety	_____	_____
Swelling in Ankles	_____	_____	Substance Abuse	_____	_____
Seizures/Epilepsy	_____	_____	Allergies	_____	_____
Deep Vein Thrombosis	_____	_____	Other	_____	_____

If you answered “yes” to any of the above, please explain and give approximate date (s):

____

____

____

Are you presently taking any medications? If “yes”, list all medications:

____

____

____

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

____ ________________

Patient/Parent/Guardian Signature Date