Aberdeen Physical Therapy

Please fill in all lines and print clearly!

Name: ____ **Date of Birth:**___/___/____

Ordering Physician:____________________________ **Primary Physician:**_______________________

Home Phone:______________________________**Cell Phone:**__________________________________

Address:____

City/State/Zip:____

Person able to speak on account/emergency contact name and number:______________________

____

With whom do you live?

Alone ____ Spouse only ____ Spouse and children ____ Children only ____ Other relatives____

Group setting____ Personal care attendant____ Other _______________________________________

Employment

Working fulltime_____

Working part-time____

Currently not working due to condition____

Homemaker____ Student____ Retired____ Unemployed____

Occupation: ____

FINANCIAL POLICY/ AUTHORIZATION AND CONSENT FOR TREATMENT

Most misunderstandings regarding insurance coverage and payments can be avoided if you are aware of the type of insurance coverage you have. If you do not know what kind of coverage you have please check with your insurance company. This is your responsibility!!

Benefits received from your insurance carrier are not a guarantee of payment. If after 90 days, your insurance company does not make payment, and we have sent all pertinent information needed, we will bill you and you will be responsible for collecting payment from your insurance company.

I authorize the release of any medical information necessary to process my claims with my insurance company. I authorize my insurance company to pay bills in connection with these claims directly to Aberdeen Physical Therapy & Fitness. I understand that I will be responsible for any charges that are not covered by my insurance company as well as my co-payment and deductibles at the time of service.

____

Signature (patient or parent/ guardian) Date

I acknowledge that I have seen the "Notice of Privacy Practices". I understand that I may ask questions about the "Notice of Privacy Practices" at any time. I hereby consent the use and disclosure of my health information for purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

____

Signature (patient or parent/ guardian) Date

LIVING ENVIRONMENT

Does your home have?

___Stairs, no railing
___Stairs, railing
___Ramps
___Elevator
___Uneven terrain

Do you use?

___Cane
___Walker
___Manual wheelchair
___Motorized wheelchair
___Glasses ___ hearing aides
Other: ___________________

Height_______ Weight________

MEDICAL HISTORY (Have you had or do you currently have any of the following?)

___Asthma, Bronchitis, Emphysema
___Shortness of Breath/Chest Pain
___Coronary Artery Disease
___Do you have a Pacemaker
___High Blood Pressure
___Heart Attack/Heart Surgery
___Blood Clot
___Stroke/TIA
___Allergies
___Pins or Metal Implants
___Joint Replacement
___Diabetes
___Infectious Disease
___Cancer ___Lymph nodes removed
___Chemo ___Radiation
___Arthritis
___Osteoporosis
___Sleeping Difficulties
___Latex Allergies

___Severe or Frequent Headaches
___Vision or Hearing Difficulty
___Numbness or Tingling
___Dizziness or Fainting
___Weakness
___Weight Loss/Energy Loss
___Hernia
___Epilepsy/Seizures
___Thyroid Trouble
___Incontinence
___Bowel or Bladder Problems
___Neck Injury/Pain
___Shoulder Injury/Pain
___Elbow/Hand Injury/Pain
___Back Injury/Pain
___Knee Injury/Pain
___Leg/Ankle/Foot Injury/Pain
___Multiple Sclerosis
___Parkinson's

Other___________________________________

MEDICATIONS PLEASE LIST AMOUNTS, FREQUENCY AND HOW ITS ADMINISTERD (ORAL, INJ, DROPS):

____

____

____

Have you ever had surgery? Yes ____ No ____

If yes, please describe, and include dates: ____

Have you had physical therapy inpatient or at home this calendar year?______________________________

Have you had physical therapy in an out patient setting this calendar year?___________________________

Is this due to an auto or workers comp accident?____

Signature ____date__________