Patient Information and Medical History

Physio Pro, Inc.

PATIENT INFORMATION:

Name: _____ Date of Birth: _____

Mailing Address: _____ ☐ Male ☐ Female

City: _____ State: _____ ZIP: _____ Home Phone: _____

Email: _____ Mobile Phone: _____

Emergency Contact: _____ Emergency Phone: _____

Do you wish to receive appointment reminders via: ☐ Text ☐ Email ☐ Voice Call ☐ None

MEDICAL HISTORY:

Are you currently taking any prescription or non-prescription medication? ☐ Yes ☐ No

List or attach all medications you are currently taking: _____

_____

Are you allergic to: ☐ Medication ☐ Latex ☐ Adhesive

List all allergies: _____

Family History: ☐ Cancer ☐ High Cholesterol ☐ Diabetes ☐ Heart Attack ☐ High Blood Pressure

Have you EVER been diagnosed as having any of the following conditions? Please check the appropriate box(es).

Cancer (type_____)	☐	Emotional/Psychological	☐	Weakness	☐
Shortness of Breath	☐	Bowel/Bladder Problems	☐	Do you smoke?	
Chest Pain (Angina)	☐	Numbness/Tingling	☐	Yes-☐ No-☐	
Night Sweats	☐	Joint Replacement	☐	Are you pregnant?	
Weight Loss	☐	Pins or Metal Implants	☐	Yes-☐ (_____months) No-☐	
High Blood Pressure	☐	Foot/Ankle Injury/Surgery	☐	Have you recently given birth?	
Coronary Artery Disease	☐	Knee Injury/Surgery	☐	Yes-☐ (Date_____) No-☐	
Heart Attack	☐	Shoulder Injury/Surgery	☐	Chemical/Alcohol Dependency	☐
Blood Clots (DVT)	☐	Neck Injury/Surgery	☐	Eating Disorder	☐
Stroke or TIA	☐	Hepatitis (Type _____)	☐	Anxiety/Panic Attacks	☐
Pacemaker	☐	Kidney Disease	☐	Asthma/Breathing Difficulty	☐
Irregular Heartbeat	☐	Urinary Incontinence	☐	Pneumonia	☐
Anemia	☐	Varicose Veins	☐	HIV/AIDS	☐
Ulcer/Stomach Problems	☐	Osteopenia	☐		
Diabetes	☐	Osteoporosis	☐	Other Illnesses diagnosed by a	
Vision/Hearing Problems	☐	Bone or Joint Infection	☐	Physician (Please List) _____	
Thyroid Disease	☐	Headaches/Migraines	☐	_____	
Fatigue	☐	Epilepsy/Seizures	☐	_____	
Depression	☐	Gout	☐	_____	

Injury and Pain Assessment

Physio Pro, Inc.

Patient Name: _____ Today's Date: _____

Briefly describe your symptoms: _____

How did your symptoms start? _____

Symptoms began on: _____

Did you receive surgery for this problem? ☐ Yes ☐ No If Yes, Date of Surgery: _____

Type of Surgery: _____ Name of Surgeon: _____

Previous Surgical History (type and date): _____

_____

Pain Rating

Are you experiencing (check all that apply): ☐ Pain ☐ Numbness ☐ Tingling ☐ Stiffness

Average pain intensity over the last 24 hours: (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Extreme pain)

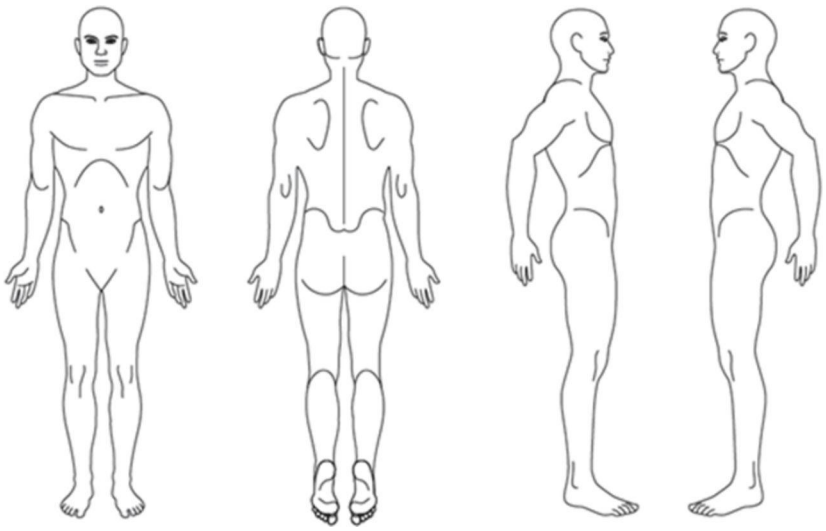
Average pain intensity over the past week: (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Extreme pain)

How often do you experience your symptoms? ☐ Constantly ☐ Frequently ☐ Occasionally ☐ Intermittently

How much have your symptoms interfered with your usual daily activities? (Both outside the home and housework)

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a Bit ☐ Extremely

In general, would you say your overall health right now is… ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor



Mark the areas where you feel the described sensations on your body using the appropriate symbol. Mark areas of radiation. Include all affected areas related to your current problem.

Pain XXXX Numbness ==== Tingling ####

HIPAA Privacy Practices

Physio Pro, Inc.

I have read and consent to the assumption of risk and release and the HIPAA practices adopted by Physio Pro, Inc. I understand that non-identifying patient data may be used in research and/or publication and consent to such use. I understand that I may obtain a paper copy of the Physio Pro Privacy Practices at any time by asking at the Front Desk.

_____ _____

Patient/Guardian Signature Date

Patient's Printed Name: _____

Consent and Liability

1. **Consent for Medical Care:** I consent to have Physio Pro, Inc., and/or its affiliates provide the treatment and care considered necessary and proper in diagnosing or treating my physical and mental condition. I understand this consent may be revoked by me at any time.
2. **Release of Information and Assignment of Insurance Benefits:** I authorize Physio Pro, Inc., or its legal representatives, to release to my insurance company or its representative any information including the diagnosis and the records of any treatment or evaluation rendered to me during the period of such care. I hereby authorize payment of medical benefits to which I am entitled to Physio Pro, Inc., for medical services rendered.
3. **Assumption of Risk and Release:** I hereby acknowledge the inherent danger and risks involved in my participation in physical therapy provided by Physio Pro, Inc., I warrant that, during the entire time I participate in physical therapy provided by Physio Pro, Inc., I will be covered at my own expense for all activities related to or arising out of such participation by a private medical and liability insurance policy.

   Understanding the above, I hereby covenant and agree that I assume all risks and responsibilities involved in participating in physical therapy through Physio Pro, Inc., and waive, release, and forever discharge Physio Pro, Inc., and their owners, directors, officers, employees, agents, or any person acting on their behalf, from any and all claims, demands, liability, and damages relating to, arising out of, or resulting from my participation in physical therapy provided by Physio Pro, Inc.

_____ _____

Patient/Guardian Signature Date

Patient's Printed Name: _____

Financial Responsibility and Insurance Policy

Physio Pro, Inc.

_____ Initial **Insurance Benefits:** It is the patient/guardian's responsibility to understand your insurance policy. As a courtesy to our patients, our office will call and research your insurance to obtain an estimate of your benefits. The coverage a patient receives depends upon the quality of the plan, NOT the fees of the therapist. The **estimate** that we provide you is based on the information we have received from your insurance company. It is not an authorization for your treatment, nor is it a guarantee of payment by your insurance company. Patients/guardians are responsible for paying all charges not covered by their insurance plans, including all fees considered above the insurance policy's usual and customary fee schedule. As the patient/guardian, you will be responsible for all costs regardless of what your insurance company determines usual and customary. **It is the insured's responsibility** to know how his/her plan works. We encourage all patients to call their insurance companies as well to verify benefits.

_____ Initial **Visit Limit/Therapy Cap:** Some insurance plans have limits on the number of visits or a specific dollar amount that are covered during the plan year. It is the patient/guardian's responsibility to know what limits the insurance policy imposes, and how many visits have been met or amount applied toward the therapy cap to date. Visits that exceed the allowed amount will be charged at our *Self Pay* rates. Some plans require authorization, which may impose further limits on the number of visits covered by insurance. The Front Desk will review your insurance company's authorization requirements with you.

_____ Initial **Supply Charges:** Dry Needling is a service we provide for which supplies *are not covered* by insurance. Other supplies may include dispensed Theraband® resistance bands or other therapeutic supplies. We will not bill insurance for these supplies, and the patient is responsible for related supply charges. Dry Needling fees are **$10 per session**. Other supply charges may be assessed on a case-by-case basis.

_____ Initial **Cancellation/No-Show Policy:** We require *24 hours' notice by telephone* for appointment cancellations. Cancellations without Notice (less than 24 hours) will be assessed a fee of $35 per instance. No-Shows will be assessed a $50 fee for the first instance and $75 for the second instance. The third No-Show will result in being discharged from our care. All fees will be charged to the credit card on file or must be paid before the patient is seen again. Exceptions will be made for emergencies, illness, and extreme weather only. Exceptions will not be made for personal scheduling conflicts that arise.

_____ Initial **Credit Card on File:** It is the practice of Physio Pro, Inc., to keep a valid, current credit card on file for all patients. This card is stored in a secure, HIPAA-compliant manner through our Electronic Medical Records (EMR) software. The card will be charged upon check-in for copays, deductible or coinsurance payments; supply charges; and for late cancellation and no-show fees. The card will **not** be charged if no fees are payable.

I acknowledge that I have read and accept the above conditions.

_____ _____

Patient/Guardian Signature Date

Patient's Printed Name: _____

Cancellation & No-Show Policy

We require at least 24 hours' notice for cancellations. For cancellations less than 24 hours before your scheduled appointment, we will charge a $35 fee. Upon your first no-show, you will be charged $50 and upon your second no-show, you will be charged $75. A third no-show will result in a discharge from the care of Physio Pro, Inc. These charges must be paid before you are seen again. Your credit card on file WILL be charged for late cancellation or no-show fees at the time of cancellation. If you are discharged, you will be required to be re-evaluated before you can be seen again.

It is your responsibility to keep track of your appointments. For your convenience, Physio Pro offers text message or email appointment reminders, along with printed schedules. Please notify the front desk if you would like to participate.

I have read the above cancellation and no-show policy and I am aware of all fees involved. I understand that my credit card on file will be charged for applicable fees at the time of cancellation/no-show.

Print Name: _____

Signature: _____