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

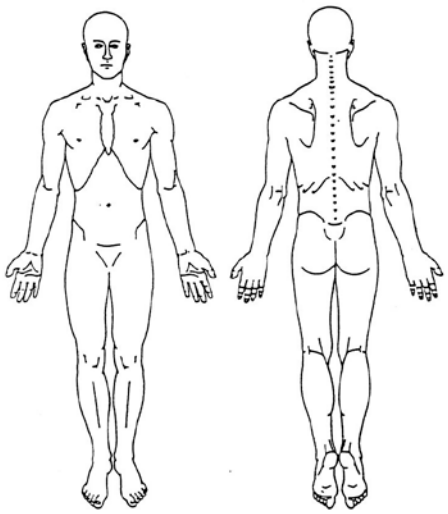
No Pain 1 2 3 4 5 6 7 8 9 10 Max Pain

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: _____

NOTE: 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.

_____**(Please Initial)** ***Compliance/Returned Check*: 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.**

_____**(Please Initial)** ***Cancellations*: 9 A.M. DAY BEFORE notification is requested when cancelling an appointment. (9 A.M. Saturday for Monday Appointments) I understand that if I cancel/NO SHOW an appointment after 9 A.M. DAY BEFORE and another patient cannot use my appointment slot, I will be personally charged a $50.00 late cancel fee.**

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

_____**(Please Initial)** ***Late Payment Charge*: I understand a $35 charge will be added to the First statement paid late. Also, $25 will be added to second and subsequent statements. All fees will be added to any collections charges for unpaid patient balances. I agree to pay this Finance Charge if it is assessed.**

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

Name:_____(print) Signature:_____ Date:_____