# FRUITVILLE PHYSICAL THERAPY

## NEW PATIENT INFORMATION

**Name:**_____
**Last First Middle**

**Address:**_____
**Street City State Zip**

**Out of Town Address:**_____
**Street City State Zip**

**Home Phone:**_____ **Work Phone:**_____

**Email:**_____ **Age:**_____ **Sex: M / F**

**Social Security Number:**_____ **DOB:**_____

**Emergency Contact Name/Relationship:**_____

**Emergency Contact Phone:**_____

**Have you had <u>HOME HEALTH</u> services within the last 90 days? Y / N**

**If yes, please provide the agency name, phone number, and date of discharge:**_____

**Is this injury <u>WORK</u> related? Y / N If yes, date of injury:**_____
**Employer's Address:**_____

**Is the injury <u>AUTO</u> related? Y / N If yes, date of accident:**_____
**Claim number:**_____

**Spouses Name/DOB(if covered under their insurance):**_____

**Primary Care Physician/Phone#:**_____

**Referring Physician/Phone#:**_____

# FRUITVILLE PHYSICAL THERAPY

Patient Name:_____

**Please read each section below and initial at the end of each statement as this will signify your agreement or understanding of each statement.**

**RELEASE OF INFORMATION**
I hereby authorize Fruitville Physical Therapy to release and/or obtain any information acquired in connection with my therapy services, including but not limited to, diagnosis and clinical records, to my insurance company, attorney, physician and/or other appropriate parties. **INITIAL HERE:**

**MEDICAL CONDITIONS**
I understand that I must inform Fruitville Physical Therapy of any conditions or disorders that may interfere with my treatment, e.g., heart condition, diabetes, high blood pressure, etc. I will inform my therapist{s} of any medical condition{s) that I now have or have had in the past. If discomfort arises, I will request assistance immediately. I also understand that if, at any time, during the course of my therapy, I am unsure as to the proper use of any equipment, I will stop immediately and consult a staff member for further instructions. **INITIAL HERE:**

**ASSIGNMENT OF INSURANCE BENEFITS / INSTRUCTION FOR DIRECT PAYMENT**
I, _____, hereby assign to Fruitville Physical Therapy any and all claim{s} proceeds relating to charges for therapy services under my insurance policy, otherwise payable to me. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. I authorize and direct that payment for covered services be made by my insurer directly to FRUITVILLE PHYSICAL THERAPY. A photocopy of this Assignment shall be considered as effective and valid as the original. _____ **INITIAL HERE:**

**MEDICARE CO-PAYMENT**
On an ongoing basis, our charges and expenses are reviewed by Medicare to ensure that they are fair and competitive. We will file your Medicare claim for you and, if you request, your supplement insurance. However, it is very important that you understand your plan of insurance is a business matter between you and your insurance company, and as the recipient of treatment, you are obligated to pay any charges which your insurance company does not pay. **INITIAL HERE:**

**THERAPY SUPPLIES**
Please be advised that therapy supplies are not covered by Medicare. If your therapist recommends a therapy supply item in connection with your treatment, payment will be your responsibility. If you have any questions, please ask your therapist.
**INITIAL HERE:**

**PAYMENT**
Payment is expected on the date services are rendered. When necessary, special arrangements can be made for a payment plan to accommodate your circumstances. If your charges are not paid in full, you will be responsible for a service charge as well as costs of collection, including up to 40% of your account balance for collection agency costs, and/or the full amount of legal fees and costs.
**INITIAL HERE:**

**APPOINTMENTS**
Please understand that your appointment represents a commitment on our part. We reserve facilities, equipment and most importantly, the time of professional personnel especially for you. If you are unable to keep your appointment, you must notify us 24 hours in advance. Failure to provide notice may result in a charge to your account, a charge for which you personally will be responsible.
**INITIAL HERE:**

**CONSENT TO TREAMENT/CONSENT OF MINOR**
I,_____, authorize, in advance, FPT to perform necessary evaluation, diagnosis, treatment and care required for my diagnosis within the scope of practice of the treating professional ie PT, PTA, SLP, OT, COTA. I, _____, parent/guardian of _____, a minor, authorize treatment by FPT as aforementioned in this paragraph. **INITIAL HERE:**

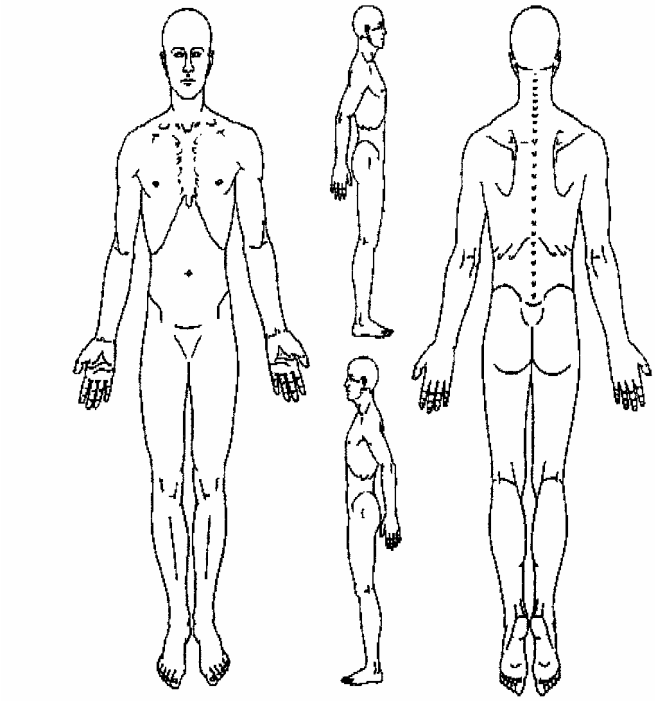
If, at any time, you have questions or concerns regarding our policies or the handling of your account, please feel free to discuss them with a member of our office staff. We look forward to working with you to make your rehabilitation both successful and pleasant. Your signature is necessary for us to process any insurance claims and to ensure payment for services rendered.

**Insured/Patient or Guardian Signature**:_____ **Date:**_____

# FRUITVILLE PHYSICAL THERAPY

## MEDICAL INFORMATION

On the diagram below, please indicate where you are experiencing pain or other symptoms, right now.



**A** = ACHE **B** = BURNING **N** = NUMBNESS
**P** = PINS & NEEDLES **S** = STABBING **O** = OTHER

**RATE YOUR PAIN TODAY**

**0 = No Pain**
**10 = Worst Pain Imaginable**

Pain level today:_____

Worst pain in last 30 days:____

Least pain in last 30 days:_____

What makes your pain:
Better_____
Worse_____

Please list medications you are currently taking:_____
_____
_____
_____

Please circle any of the following medical conditions you may have been diagnosed with/or have experienced:

| | | | | |
|---|---|---|---|---|
| Cancer | Heart Disease | Allergies | Arthritis | Dizziness |
| Emphysema | Diabetes | Chest Pain | Asthma | Liver Disease |
| Pneumonia | Polio | Hypoglycemia | Kidney Disease | Hepatitis/Jaundice |
| Ringing Ears | Stroke | Reiter's | Hypertension | Urinary Tract Infection |
| Ulcers | Gout | Pacemaker | Pregnancy | Rheumatic Fever |
| Shortness of Breath | | Irritable Bowel Syndrome | | Chronic Bronchitis |

Please note any other past medical problems, illnesses, surgeries, or hospitalizations:

---

I certify that the above information is true and complete to the best of my knowledge:

Signature:_____ Date:_____

# FRUITVILLE PHYSICAL THERAPY

## NOTICE OF PATIENT INFORMATION PRIVACY PRACTICES
## PATIENT CONSENT FORM

I have read and fully understand the **Notice of Patient Information Privacy Practices**. I understand that my protected health information may be used or disclosed for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and administrative healthcare operations. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the practice. I also understand that my request for restriction will be considered on a case-by-case basis, but my request for restrictions may not be honored based on the reasonableness of the request.

I hereby consent to the use and disclosure of my protected health information for purposes as noted in the **Notice of Patient Information Privacy Practices**. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time. I understand that the practice has the right to change its **Notice of Patient Information Privacy Practices** and that I may contact this organization at any time to obtain a current copy of this notice.

_____
Patient's Printed Name

_____ _____
Signature of Patient or Guardian Date

---

## AUTHORIZED DESIGNEES

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Name:_____ Relationship:_____
Name:_____ Relationship:_____
Name:_____ Relationship:_____
Name:_____ Relationship:_____

_____ _____
Signature of Patient or Guardian Date

---

**FOR OFFICE USE ONLY:**
The above noted patient was provided with this consent form and the **Notice of Patient Information Privacy Practices**, but refused to sign this consent form for the following reason:

_____

_____

_____ _____
Staff Signature Date

FILENAME: HIPAAFORM04 Consent to Privacy Practices