Patient Information

First Name_____ MI____ Last Name_____DOB_____/_____/_____ Sex M F (circle)

Address _____City_____State_____Zip_____

Primary Phone_____Secondary Phone_____Email _____

I would like to receive appointment reminders via ☐ text ☐ phone call (mark one)

☐ Please check this box if you do NOT want to receive email newsletters, updates, and condition-specific health tips

Employer_____ Occupation_____ Work Phone_____

Emergency Contact_____ Phone_____Relation _____

Where did you hear about ProTailored?_____

Primary Insurance_____Insured Party_____

Relation to Insured_____ DOB____/___/_____Insured's Address_____

Secondary Insurance_____Insured Party_____

Relation to Insured_____ DOB___/___/_____Insured's Address_____

If Medicare is secondary state reason:

☐ working aged benefit ☐ disabled benefit ☐ veteran's admin ☐ work comp ☐ public health ☐ other

Missed Appointment Policy

All appointments require a <u>24-hour</u> cancellation notice to avoid a <u>$50 missed appointment fee.</u>

We, along with your physician, have given time and thought to your treatment plan, but it will not work if you are not here. Your therapist is committed to your recovery and has reserved a 40 minute one-on-one block of time in their schedule for each appointment you make; we expect the same commitment from you by keeping your scheduled appointments as this can mean the difference between whether you succeed in therapy or not. Please attend your appointments on time, as tardiness not only affects your care, but the care of others. If you know you are going to be more than 10 minutes late, PLEASE CALL. You will be charged a $50 administrative fee (which is not refunded by insurance) for not showing up to your appointment or cancelling with less than a 24 hour notice. If you do not show up to two or more of your appointments, services may be discontinued due to non-compliance.

I affirm the information above is correct, and I understand the missed appointment policy

_____

Signature of Patient or Responsible Party Date

Medical Information

Primary Care Physician_____Referring Physician_____

****Direct Access Patients Only:** *In the state of Indiana, you can receive physical therapy services for 24 days without a script from a physician. If you would like our office to work on obtaining a script on your behalf so that you may be treated beyond the 24 days, please identify a physician you'd like us to contact in order to receive a script for you:*

Please reach out to _____ (Doctor's name) to obtain a script for my PT treatment.

Seeking treatment for_____Pain Onset/Injury Date_____

Any imaging (X-Ray/MRI) relating to the area of concern? Yes No If so, where and when?_____

Are you receiving or have you recently received home health services? ☐ Yes ☐ No

Are you receiving or have you recently received other therapy services? ☐ Yes ☐ No

If "Yes", please explain_____

Do you have any allergies? ☐ Yes ☐ No

If "Yes", please list_____

Please list any surgeries or other conditions for which you have been hospitalized:

Date	Reason for Surgery/Hospitalization	Date	Reason for Surgery/Hospitalization
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Could you be, or are you, pregnant? ☐ Yes ☐ No

Please check any of the following which you have recently noticed:

☐ Weight loss/gain ☐ Nausea/vomiting ☐ Fatigue ☐ Weakness ☐ Fever/chills/sweats ☐ Numbness/tingling

Are you presently taking any medications? ☐ Yes ☐ No

If "Yes", please list (or provide a copy of medication list)_____

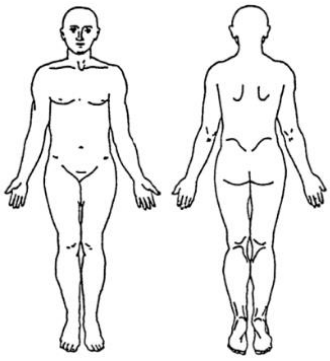
Which of the following conditions are you currently being treated or have been treated for in the past? (please check)

- ☐ Cancer
- ☐ Other arthritic conditions
- ☐ Depression
- ☐ Anxiety
- ☐ Tuberculosis
- ☐ Kidney disease
- ☐ Epilepsy/Seizures
- ☐ High/Low blood pressure
- ☐ Asthma
- ☐ Pacemaker
- ☐ Diabetes
- ☐ Shortness of breath
- ☐ Rheumatoid arthritis
- ☐ Osteoporosis
- ☐ Hepatitis
- ☐ Stroke
- ☐ Anemia
- ☐ Heart problems
- ☐ Circulation problems
- ☐ Emphysema/Bronchitis
- ☐ Thyroid problems
- ☐ Multiple sclerosis
- ☐ Recent weight loss/gain
- ☐ Latex Allergy

If you checked any of the above or have other conditions not listed, please explain:

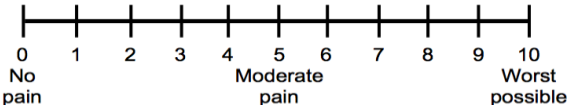
_____

Circle the parts of the body that are currently giving you discomfort:

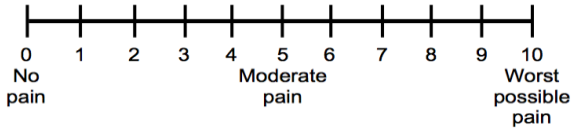


Using the scales below, indicate your pain levels by circling the appropriate number on the following scales.

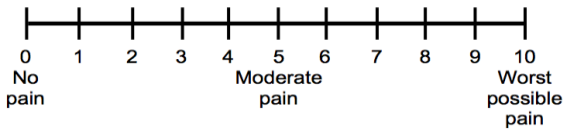
Please rate your **current** level of pain:



Please rate your **worst** level of pain in the last 24 hours:



Please rate your **best** level of pain in the last 24



Patient Authorization

Release of Information and Consent for Treatment

All information provided herein is true and correct. I am aware of my diagnosis and wish to receive treatment at ProTailored Physical Therapy, LLC. I permit its employees and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand that this care can include an evaluation, testing, and treatment. No guarantees have been made to me about the outcome of this care.

I give permission to ProTailored Physical Therapy, LLC to release information, verbal and written, contained in my medical record and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, school, related health care provider, assignees, beneficiaries, and/or all other related persons as it relates to my treatment and/or payment for services provided.

I authorize ProTailored Physical Therapy, LLC to obtain medical records and/or professional information from my physician and/or other medical professional as it relates to my treatment.

The initials below certify that I have read and understand the above information:

Initial_____

Assignment of Benefits

I authorize payment directly to ProTailored Physical Therapy, LLC for services and to bill and release payment directly to ProTailored Physical Therapy, LLC for any physical therapy services provided. This is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original. My signature affixed here may be kept on file to suffice for any signatures required on insurance claim forms.

Initial_____

Notice of Privacy Practices
(HIPPA Acknowledgement/Consent)

I hereby acknowledge that I have received a copy of The Notice of Privacy Practices for ProTailored Physical Therapy, LLC. In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment, and health care operations. I understand the risks associated with the use of email and text messaging as a form of communication between the ProTailored staff and me, as well as any other instructions that ProTailored may impose to communicate with me by email or text message. I consent to ProTailored sending me letters via email. Emails are sent through the MailChimp email service. I understand that they are sent via a public network to a personal email address and as such may not be secure. I agree to advise the practice if my email address changes.

Initial_____

Payment Guarantee

I agree to pay ProTailored Physical Therapy, LLC for the services provided to me. If any law, such as workers' compensation or insurance contract, prohibits payment for the services, I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for speedy collection from my third-party payer. I acknowledge and understand that payment for services may be denied by my insurance carrier, including, but not limited to, pre-existing conditions, routine, experimental, not reasonable or necessary, or work related reasons. Where the law or an insurance contract does not prohibit payments by me, I acknowledge responsibility for any and all account balances. If my insurance pays me directly, I agree to forward the payment to this office within 10 days of my receipt of payment. I further understand that failure to comply with this policy could result in ProTailored Physical Therapy, LLC taking appropriate legal action to collect this amount. I acknowledge that I am financially responsible for all fees incurred for services rendered regardless of insurance. Any balance on my account that remains unpaid for more than 60 days may be assessed a rebilling fee of $25.00. If a balance remains unpaid for more than 90 days, the account may incur an additional $50.00 rebilling fee. Once a balance goes unpaid past 100 days, the account may be turned over to a Third-Party Billing Service. You agree that you will pay interest that can be added at the current legal rate as well as all collection fees, returned check fees, attorney fees and court costs incurred for the collection of all sums due.

The Benefit Verification form is only an explanation of coverage obtained from my insurance company and it is not a guarantee of coverage. If the information provided by my insurance company is not accurate or the insurance company changes its coverage, I will be responsible for payment for services. I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my treatments unless agreed to in writing by myself and a representative of ProTailored Physical Therapy, LLC.

Additional Fees:

- A fee of $25 will be charged for any returned check
- Any supply of durable medical equipment provided to me will exclusively be my financial responsibility and will need to be paid for at the time of purchase

Initial_____

Designated Individuals Authorization Form

I hereby authorize one or all of the designated parties listed 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.

Authorized Designees:

Name_____ Relationship_____Phone_____

Name_____ Relationship_____Phone_____

I certify that I have read, understood, and filled out all the information in this packet accurately to the best of my knowledge:

Patient Name_____Patient/Guardian Signature_____Date____

Witness Signature_____Date_____