Palmetto Physical Therapy

Patient Name First _____ MI _____ Last _____

Preferred Name _____ Address Street _____ Apt # _____

City _____ State _____ Zip Code _____

SSN _____ Driver's License # _____ State _____

Date of Birth _____ Phone # _____ Cell # _____

Employer _____ Work # _____ Ext. _____

Emergency Contact _____ Relationship _____ Phone # _____

Primary Care Doctor _____ Phone # _____

Referring Doctor _____ Phone # _____

Primary Health Insurance Company _____ Insurance ID card copied for chart _____

You must complete if you are not the insured: First Name _____ MI _____ Last _____

SSN _____ Date of Birth _____ Relationship to insured _____

Secondary Health Insurance Company _____ Insurance ID card copied for chart _____

You must complete if you are not the insured: First Name _____ MI _____ Last _____

SSN _____ Date of Birth _____ Relationship to insured _____

Is there someone with whom you would like us to be able to discuss your on going care? Yes _____ No _____

If yes, Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

Were you involved in an accident? Yes _____ No _____

If yes, give details _____

_____

Name of attorney _____

PPT's policy is to file your insurance at the time of service as a courtesy to patients; however, if you have commercial insurance, are self-pay, or are out of network, you will be asked to pay at time of service. If your insurance has not paid within 60 days, you will be responsible for all charges incurred. We will accept cash, personal checks, or credit cards (Visa, MC, and Discover). I understand that I am ultimately responsible for charges incurred at PPT regardless of third party liability. **Initial** _____

It is important to recognize that the appointment time given to you is reserved for you alone, as we do not double book our schedule. We schedule appointments in this fashion to minimize any waiting on your part. We require at least 24 hours notice if you need to reschedule. Should an emergency arise which causes you to miss or be late for an appointment, we ask that you call as soon as possible. **Initial** _____

There is a $25 charge for cancellation without proper notice.
This charge will not be covered by insurance but will have to be paid by you personally. **Initial** _____

Consent to Treat and Authorization to Release Information

I consent to evaluation and treatment by PPT and realize that I have the right to refuse any procedure after having the risks and benefits explained to me.

I authorize the release of information acquired in the course of my treatment, including, but not limited to medical records, electronic media, and oral communications, to my insurance company representatives, employer, primary care physician, referring physician, and/or other third party payer.

I authorize phone messages regarding my treatment and appointments to be left with persons or machines at the phone numbers I have provided.

A copy of this facility's Statement of Privacy Notice has been provided to me. **Initial** _____

Patient's Signature _____ Date _____

Signature of Responsible Party _____ Relationship _____ Date _____
(if different than patient)

Palmetto Physical Therapy

Patient Name _____ Date _____ Age _____

The following confidential information will assist us in treating you more effectively. Discuss questions with your therapist.

1. Have you ever been diagnosed or treated for any of the following? (please check)

- ❑ Cancer
- ❑ Diabetes
- ❑ Hypertension / High Blood Pressure
- ❑ Heart Disease
- ❑ Angina/Chest Pain
- ❑ Shortness of Breath / Asthma
- ❑ Stroke
- ❑ Kidney Disease / Infection
- ❑ Insomnia
- ❑ Osteoporosis
- ❑ Hepatitis / Liver Disease
- ❑ Emphysema
- ❑ Migraine Headaches
- ❑ Ulcers / Stomach Problems
- ❑ Allergies
- ❑ Depression
- ❑ Recent Weight Loss / Gain
- ❑ Epilepsy / Convulsions
- ❑ Thyroid Problems
- ❑ Tuberculosis
- ❑ Rheumatoid Arthritis
- ❑ Chills / Night Sweats

2. List any past surgeries, hospitalizations and dates _____

_____

Do you have any implants? (plates, screws, staples) Yes _____ No _____

3. Have you had any x-rays, sonograms, computed tomography (CT), or magnetic resonance (MRI) done lately? Yes _____ No _____

If yes, please explain when, where and the results _____

_____

4. Have you had any lab work recently? Yes _____ No _____

If yes, please explain when, where and the results _____

_____

5. List types of prescriptions and over-the-counter medications you are taking _____

_____

6. Do you smoke cigarettes, a pipe, or chew tobacco? Yes _____ No _____

7. FOR WOMEN ONLY:
   a. Are you pregnant? Yes _____ No _____
   b. Are you menopausal? Yes _____ No _____
   c. Are you taking estrogen / hormonal replacement therapy? Yes _____ No _____

8. Have you had physical therapy before? Yes _____ No _____

9. When do you return to see your physician? _____

Signature of person completing form _____ Date _____

Referred by _____ Date _____