Exemplar PHYSICAL THERAPY

Patient Information			
Last Name	First Name	MI	Date of Birth
Social Security Number	Marital Status ☐ S ☐ M ☐ W ☐ O	Sex ☐ M ☐ F ☐ O	
Address	City	State	Zip
Home Number	Mobile Number	Email	
Employer Name (Required for Worker's Comp Patients)	Employer's Phone Number	Employer's Contact Name	
Preferred Method of Contact: Fill in the blank: Mobile or email Home Number Mobile Number Email			

Emergency Contact		
Primary Emergency Contact Name	Phone Number	Relation to Patient
Secondary Emergency Contact Name	Phone Number	Relation to Patient

Referral Information	
Referring Physician Name	Referring Physician Phone Number
Referring Physician Address	
Primary Care Physician Name	Primary Care Physician Phone Number
Primary Care Physician Address	

Patient or Parent/Guardian Signature	Date
X	

Insurance Information		
Primary Insurance Name		Primary Insurance Phone Number
Member/Subscriber ID Number	Group Number	Relation to Patient
Name of Insured (If other than patient)		Date of Birth of Insured (If other than patient)
Secondary Insurance Name		Secondary Insurance Phone Number
Member/Subscriber ID Number	Group Number	Relation to Patient
Name of Insured (If other than patient)		Date of Birth of Insured (If other than patient)

Worker's Comp Complete this section if your injury/condition is related to a work injury.	
Worker's Comp Insurance Carrier	Worker's Comp Insurance Carrier Phone Number
Claim Number	Accident Date
Adjustor's Name	Adjustor's Phone Number

Auto Insurance	
Auto Insurance Carrier	Auto Insurance Carrier Phone Number
Claim Number	Accident Date
Adjustor's Name	Adjustor's Phone Number

Consent to Physical Therapy Evaluation and Treatment

Physical Therapy is a patient care service that is provided in order to manage and treat a wide variety of conditions. Services are provided to individuals of all ages regardless of gender, ethnicity, creed, national origin, or disability.

The purpose of physical therapy is to prevent and treat disease, injury, and disability through examination, evaluation, diagnosis, prognosis, and intervention by use of rehabilitative procedures, mobilization of joints and soft tissues, manipulation, exercises, patient education, and physical agents to help the patient reach their greatest potential within their capabilities, to accelerate convalescence, and to reduce the length of functional recovery. All procedures will be thoroughly explained to you as needed and requested before you are asked to perform or participate in them.

Response to physical therapy intervention varies form person to person, hence it is not possible to accurately predict your response to a specific procedure, exercise protocol, or modality. Exemplar Physical Therapy, Inc. and Exemplar Health Services does not guarantee what your reaction will be to a specific treatment, nor does it/she guarantee that the treatment will help resolve the condition for which you are seeking treatment. Furthermore, there is a possibility that the physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury.

It is your right to decline any part of your treatment at any time before or during treatment, should you feel any discomfort, pain, or have other unresolved concerns. It is your right to ask your physical therapist about the treatment they have planned based on your individual history, physical therapy diagnosis, symptoms, and examination results. Consequently, it is your right to discuss the potential risks and benefits involved in your treatment.

I have read this consent form and understand the potential risks involved in physical therapy. I understand that the success of my treatment depends on my ability and willingness to cooperate and participate in all physical therapy procedures and comply with the established plan of care.

By my signature below, I certify that I have read, understand, and fully agree to the statement in this section and sign below freely and voluntarily.

Patient or Parent/Guardian Signature	**Date**
X	

Reassignment of Benefits

I authorize payment of medical benefits to Exemplar Physical Therapy, Inc. and Exemplar Health Services for services rendered. Exemplar Physical Therapy and Exemplar Health Services will make reasonable effort to collect insurance proceeds by completing insurance forms and sending them to the insurance company. Completion of such forms and/or the acceptance of assignment of insurance benefits does not relieve the undersigned of the obligation to pay the amount owed for services rendered.

By my signature below, I certify that I have read, understand, and fully agree to the statement in this section and sign below freely and voluntarily.

Patient or Parent/Guardian Signature	**Date**
X	

Exemplar PHYSICAL THERAPY

Financial and Cancellation Policy

ALL PAYMENTS ARE EXPECTED AT THE TIME OF SERVICE

Please note, all payments for deductibles, co-insurances, and/or co-payments are due at time of service, unless you provide the clinic with a debit, credit, HSA, or FSA card for automatic payment deductions of amounts due.

Note that payments made at time of service are for an estimated amount based on the benefit information provided by your insurance company, and not the exact amount you will owe for any given date of service. Final dollar amount due for services will be determined after your insurance processes your claim.

The clinic accepts cash, personal checks (in-state only), VISA, MasterCard, American Express, and Discover. There is a $25.00 service charge for returned checks.

Patients with an outstanding balance 60 days or older may be forwarded to a third party collection agency.

INSURANCE

Our office will check your benefits as a courtesy to you and provide this information on or before your first appointment. The benefit information we will provide for you is only a quote of benefits, so it is not a guarantee that we will receive payment from your insurance company for services rendered. The actual benefit for services provided will be determined by your insurance once they receive your claim.

We bill participating insurance companies as a courtesy to you. You are expected to pay your deductible, co-insurance, and/or co-payment at the time of service. If we have not received payment from your insurance company within 60 days of the date of service, you may be expected to pay the balance in full. Please note, even though we will bill your insurance carrier, you are still responsible for payment of all services rendered whether by you or your insurance company.

REFUNDS

Patient/guarantor credits will automatically be refunded to the patient/guarantor once all services are paid.

CANCELLATION AND NO-SHOW POLICY

Please contact our office if you cannot come to a scheduled appointment. If you do not call 24 hours prior to your scheduled appointment time, there will be a $50 late cancellation fee. Failure to call or show for a scheduled appointment will result in a $50 no-show fee.

By my signature below, I certify that I have read, understand, and fully agree to the statement in this section and sign below freely and voluntarily.

Patient or Parent/Guardian Signature	Date
X	

Exemplar PHYSICAL THERAPY

Medical History Form

Name _____ Date Symptoms Began_____

In a few words, describe your symptoms _____

_____

Are you symptoms related to an accident? If yes, please describe the accident_____

_____

Did your illness/injury required surgery? Y N If yes, please provide the date of surgery_____

Please provide a list of all medications you are currently taking

_____

_____

Have you been diagnosed with any of the following conditions? List in box below all that apply.

- Arthritis
- Bones Fractures
- DisablingHeadaches
- Heart Problems
- Paralysis
- Spine Issues
- Asthma
- Convulsions
- Disc Trouble
- Osteoporosis
- Muscle Weakness
- Tumor or Cancer
- Blood Pressure
- Problems Diabetes
- Fainting Spells
- Pacemaker Implantation
- Pregnancy
- Dizziness

Other conditions _____

Did you have any diagnostic testing for your current condition? Not yet

X-rays CT Scan Bone Scan EMG Nerve Conduction Study MRI

Other _____

Rate your pain intensity on a scale of 0-10. (0 being no pain)

Current pain ____ /10

At best ____ /10

At worst ____ /10

Rate your current and prior level of function on a scale of 0% to 100% (100% being you are fully functional)

Current _____

Prior _____

Patient or Parent/Guardian Signature	**Date**

Acknowledgement of Receipt of Notice of Privacy Practices	
I certify that I have received a copy of the Notice of Privacy Practices of Exemplar Physical Therapy. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills, or in the performance of Exemplar Physical Therapy health care operations. The Notice of Privacy Practices also describes my rights and Exemplar Physical Therapy's duties with respect to my protected health information. The Notice of Privacy Practices is also available at the front desk area and on the Exemplar Physical Therapy website at www.examplarpt.com. Exemplar Physical Therapy reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, asking for one at the time of my next appointment, or accessing the Exemplar Physical Therapy website.	
By my signature below, I certify that I have read, understand, and fully agree to the statement in this section and sign below freely and voluntarily.	
Patient or Parent/Guardian Signature	**Date**
X	