Alton Physical Therapy, P.C.

Getting people better one patient at a time and we'll start today.

Today's Date ______________________

Patient's

Last/First ______________________

Address ______________________

City __________ State ______ Zip ________

Home Phone ______________________

Work Phone ______________________

Cell Phone ______________________

SSN ______________________

Sex __________ Date of Birth ____________

Employment Status: FT PT Retired Student Umpl

Marital Status ______________________

Employer ______________________

Employer Address ______________________

City __________ State ______ Zip ________

Occupation ______________________

Are you or think you may be pregnant? Yes No

Do you have a pacemaker? Yes No

In Case of Emergency, Please Contact:

Name ______________________

Relationship ______________________

Home Phone ______________________

Cell Phone ______________________

Email ______________________

Referring Physician ______________________

Primary Physician ______________________

Next MD Appt ______________________

DX/Chief Complaint ______________________

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Date of 1st. Symptom or Injury ______________________

Was this an accident? Yes No

Accident Type Work Auto Other

If this was an accident,

Date of accident ______________________

State in which accident occurred ____________

Rate you pain level from 0-10. 0 = No pain 10 = Worst

Now: __________

At worst: ________

At best: __________

Medications: ______________________

____

____

Surgical History ______________________

____

____

Please Provide Insurance cards to Office Staff and fill in information below if the Insured is not SELF.

Primary Insurance

Insurance Co. ______________________

Insured's Name ______________________

Address ______________________

City __________ State ______ Zip ________

SSN ____________ DOB ____________

Relationship to Patient ______________________

Employer ______________________

Secondary Insurance

Insurance Co. ______________________

Insured's Name ______________________

Address ______________________

City __________ State ______ Zip ________

SSN ____________ DOB ____________

Relationship to Patient ______________________

Employer ______________________

Consent to Medical and related Health Care: I request and consent to the medical care and treatment procedures as determined necessary by my physician(s). I acknowledge the care I receive while in this facility is under the direction of my physician(s).

Medical and Allied Health Care Providers: I have been informed and understand that the Physical Therapist providing services to me in this facility are not independent contractors and are employees of this facility unless otherwise specifically identified.

Teaching Programs: I understand this facility may, from time to time, enter into agreements with academic programs. Because of these agreements, physical therapy students may participate in my care. I agree to participate in these programs, but have the right to limit my participation at any time.

Patient Rights: I acknowledge access to the Patient Rights information explaining my rights as a patient at this facility.

Personal Property: I have been informed and understand this facility will not be liable for any loss of my personal property unless it is inventoried and placed in a secured area maintained by this facility.

Payment for Medical and Related Care, splints and durable medical equipment (DME): I agree to pay the charges incurred for the care I received as ordered by my physician(s) at this facility. I guarantee full payment of all charges unless restricted by Medicare. These charges include, but are not limited to if necessary, to stabilize an emergency medical condition. In the event that I fail to pay these charges, I understand that I will be responsible for reasonable collection costs and attorney fees associated with the cost of resolving my account.

Assignment of Benefits: I hereby irrevocably assign and transfer to THIS FACILITY any and all benefits, either contractual, common law, or statutory, to which I am entitled or which are available to me under any medical, health, and accident, or workers' compensation policy, plan, or program. I hereby authorize and direct that any such payments be paid directly to THIS FACILITY. Should my insurance policy, or plan description, prohibit direct payment to providers, I direct the Payor to issue the provider a check payable to THIS FACILITY and myself. I further authorize and agree that a copy of this authorization shall be deemed valid as the original.

Cancellations or Late Arrivals: Appointments are made to save the patient time and prevent unnecessary waiting and delay. Many people are inconvenienced when an appointment is missed you, every patient following you and the therapist. If for any reason this appointment cannot be kept or you will be arriving late, notification should be made as far in advance as possible. Your attention to this matter will be greatly appreciated.

I have read and understand the above agreement.

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Patient/Responsible Party Signature　　　Relationship　　　Date

If Patient is a minor:
I give consent for treatment of the above named minor child by Alton Physical Therapy. P.C. and or its affiliated offices.

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Parent/Legal Guardian Signature　　　Date

Witness:

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Facility Employee Signature　　　Date