STATEMENT OF FINANCIAL RESPONSIBILITY

All Care Physical Therapy appreciates the confidence you have shown in choosing us to provide your rehabilitative needs. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, *you are ultimately responsible for any co-payment at the time of service and on receipt of a bill for any deductible/co-insurance as determined by your insurance carrier*. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amount not covered by your insurer. If your insurance carrier denies any part of your claim, or if you and your physician elect to continue therapy past your approved period, you will be responsible for your account balance in full.

I authorize my insurer to pay any benefits directly to All Care Physical Therapy. I agree to pay All Care Physical Therapy the full amount of all bills incurred by me, and if applicable, any amount due after payment has been made by my insurance carrier.

CONSENT OF TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the Physical Therapist employed by All Care Physical Therapy to examine and treat the condition he/she deems appropriate through the use of therapy measures, and the patient gives authorization for these procedures to be performed. I further authorize All Care Physical Therapy to release to appropriate agencies, any information acquired during my, or the above-named patient's, examination and treatment necessary to secure payment for services provided. I acknowledge that the Notice of Privacy Practices are available upon request to review prior to signing this document. I further acknowledge that I have the right to request a copy of the notice and one will be provided to me.

MISSED APPOINTMENT POLICY

We strive to provide our patients with excellent service and quality care. Our commitment to your well-being and health is something that we take very seriously, and your attendance is imperative to achieving a proper recovery. An appointment card will be provided to you to keep track of your appointments.

You are expected to attend all scheduled appointments; however, should you need to cancel, please note that 24-hour notice is required. If you need to cancel your appointment, please call our office to reschedule. If cancellations are not received within 24 hours, or if you do not show for your appointment, we reserve the right to charge $35.00 for the missed appointment.

We thank you for choosing All Care Physical Therapy and we look forward to working with you and helping you reach your goals.

I have read the above policies, and I certify that the information provided is true and accurate to the best of my knowledge.

Patient/Guardian Signature: ____ Date: __________________________

PATIENT INFORMATION-To be completed by patient			
First Name:	Last Name:		
Address:	City:	State:	Zip:
Date of Birth:	Birth Sex:	SS#	
Home Phone#:	Cell Phone #:		Email:
Would you like to receive appointment reminders? Please Circle Yes No	☐ Text	☐ Call	☐ Email
Employer:	Occupation:		

EMERGENCY CONTACT- To be completed by patient	
Name:	Relationship to Patient:
Home Phone #:	Cell Phone #:

INSURANCE INFORMATION- To be completed by patient (DO NOT FILL IN IF WE HAVE COPIES OF INSURANCE CARDS)		
Primary Insurance:	Policy ID#:	Group #:
Subscribers Name:	Subscribers DOB:	Relationship to Subscribers:
Secondary Insurance:	Policy ID#:	Group #:
Subscribers Name:	Subscribers DOB:	Relationship to Subscribers:

AUTO OR WORK INJURY CLAIMS ONLY-To be completed by patient	
Auto Insurance Name:	Worker Comp Carrier:
Adjuster/Claims Manager:	Phone#:
Claim#:	Accident Date:

HEALTH HISTORY

Patient Name: ________________________________ Today's Date: _________________________________

Referring Physician: ___________________________ Primary Care Physician: ________________________

Date of Injury: ________________________________ Date of Surgery: _______________________________

Are you currently under any restrictions from your doctor? ____

Chief Complaint (Reason for your visit today)? ____

Approximately when did this pain begin? _________________________________

Please list any additional areas of pain: ____

Please rate your pain from 0 to 10. ________ (0 = no pain, 10 = intense)

What caused your current condition? □ Accident □ Overuse □ Sports Injury □ Unknown □ Work □ Other

Since your pain began, how has it changed? □ Improved □ Worsened □ Stayed the Same

When is your pain at its worst? □ Mornings □ Daytime □ Evenings □ Middle of Night □ Always the same

How often does the pain occur? □ Constant □ Changes in severity but always present □ Intermittent (comes and goes)

Have you seen anyone else for your current condition?

□ Physician/MD □ Chiropractor □ Orthopedic Surgeon □ Dentist □ Neurologist □ Other (Specify: ___________________)

Please check any tests or procedures that have been performed for your current condition:

□ X-Rays □ MRI □ CT Scan □ Bone Scan □ EMG □ Blood Work □ Bone Density □ Ultrasound

Have you had a related surgery? ____________________________ Date of Surgery: ________________________________

Have you fallen within the past year? Yes □ No □ If yes, any injuries? _________________________________

Do you exercise regularly? Yes □ No □ If yes, how often? __________________________________

Height: __________ Weight: _____________

PAST MEDICAL HISTORY

Have you ever had any of the following conditions and/or symptoms?

Check all that apply.

□ Cancer	□ Diabetes	□ Allergies
□ Chest Pain/Angina	□ Hypoglycemia	□ Pacemaker
□ Heart Disease	□ Bowel/Bladder Abnormalities	□ Heart Attack
□ Dizziness/Vertigo	□ Stroke/CVA □ □ Smoker	□ Peripheral Neuropathy
□ Recent Falls	□ Osteoporosis	□ Metal Implants
□ Fractures Where? _______	□ Asthma/Breathing Difficulties	□ Positive for HIV or Hepatitis
□ High Blood Pressure	□ Joint Replacement	□ Fibromyalgia
□ Difficulty Hearing	□ Other Conditions: ________________________________	

Medications: List any prescribed or over-the-counter medications or supplements you are currently taking:

____

____

____

Surgeries: List any previous surgeries and dates:

____

____

____

Patient/Guardian Signature: ____