New Patient Information

Date:_____ Marital Status: Married Single Divorced Widowed

Patient Name:_____ Name of Spouse/Parent: _____

Address: _____

Zip Code: _____ Date of Birth: _____ Social Security #: _____

Phone #:( ) _____ Age: _____ Sex: _____ Driver's License#: _____

Party Responsible for Payment: _____ DOB: _____

Relationship: Self` Spouse Natural Child Step Child Foster Child Other _____

Address of Party Responsible for Payment: _____

Zip Code: _____ Drivers license#:_____ Phone #: ( ) _____

Employer Name: _____

Address: _____

Zip code:_____ Phone #: ( )_____

Referring Physician: _____ Next Physician Appointment _____

**We bill $25 for a no-show (when you do not notify us you will not be in for an appointment). If you miss 3 appointments you may be dismissed from this practice.*

Please initial: _____

Insurance Information

Primary Insurance: _____ Phone #: ( )_____

Policy Holder's Name:_____

ID #: _____ Group #: _____

Secondary insurance: _____ Phone #: _____

ID #: _____ Group #: _____

Is Injury Employment Related? Yes No Claim#:_____

Is Injury Auto Related? Yes No Date of Injury: _____

Attorney: _____ Phone: ( )_____

121 Cranberry Road ● Grove City, PA 16127 ● 724-458 WISE
110 Arrowhead Drive Suite 200 ● Slippery Rock, PA 16057 ● 724-406-0506

1. CONSENT FOR TREATMENT

I understand that I have been referred to Wise Physical Therapy and Sports Medicine by my physician for physical therapy services. I will be subject to various therapeutic procedures and modalities, such as moist heat, cold packs, ultrasound, electrical stimulation, traction exercise, mobilizations, and other organized procedures utilized by physical therapists. I hereby authorize Wise Physical Therapy and Sports Medicine to treat me as prescribed. If the patient is under the age of 18, a parent or guardian must sign this consent form.

_____

Patient Signature or Parent/Guardian — Date

2. CONSENT FOR RELEASE OF INFORMATION

I hereby consent to the release of information concerning my physical condition to third party payers involved in processing claims for payment of treatments administered by Wise Physical Therapy and Sports Medicine. I consent to the use of chart information for research purposes.

_____

Patient Signature or Parent/Guardian — Date

3. CONSENT FOR PAYMENT AND ASSIGNMENT OF BENEFITS

I understand that I am financially responsible to Wise Physical Therapy and Sports Medicine for any debts not covered by third party payers which are incurred during the period of time in which I am receiving treatment as prescribed by my physician. I understand that any returned check for insufficient funds will incur a $25 fee. I agree to forward to Wise Physical Therapy and Sports Medicine any payments received at my residence for services administered during the period I am receiving treatment. I hereby assign my/our right to receive payment for services rendered for physical therapy, Wise Physical Therapy and Sports Medicine.

_____

Patient Signature or Parent/Guardian — Date

4. MEDICARE ASSIGNMENT OF BENEFIT AND RELEASE OF INFORMATION

I hereby request that payment of authorized Medicare benefits be made on behalf of Wise Physical Therapy and Sports Medicine for any services incurred by me. I authorize the holder of medical information about me to release any information needed by the Health Care financing Administration and its agents in order to determine benefits payable in my behalf.

_____

Patient Signature or Parent/Guardian — Date

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PF-2000 Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of Your Protected Health Information

Your protected health information will be used by Wise Physical Therapy and Sports Medicine or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your protected health information.

Wise Physical Therapy and Sports Medicine may or may not agree to restrict the use or disclosure of your protected health information.

If Wise Physical Therapy and Sports Medicine agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices

Wise Physical Therapy and Sports Medicine reserves the right to modify the privacy practices outlined in the notice.

Signature

I have reviewed this consent form and give my permission to Wise Physical Therapy and Sports Medicine to use and disclosure my health information in accordance with it.

_____
Name of Patient (Print or Type)

_____
Signature of Patient

_____
Date

_____
Signature of Patient Representative

_____
Relationship of Patient Representative to Patient

Patient Name _____ **Date:** _____

Medical Record – Supplemental Medical Data

Circle YES or NO…

Have you or any immediate family member ever been told you have:

	Self		Family	
Cancer?	Yes	No	Yes	No
Diabetes?	Yes	No	Yes	No
High blood pressure?	Yes	No	Yes	No
Heart disease?	Yes	No	Yes	No
Angina/chest pain?	Yes	No	Yes	No
Stroke?	Yes	No	Yes	No
Osteoporosis?	Yes	No	Yes	No
Osteoarthritis?	Yes	No	Yes	No
Rheumatoid arthritis?	Yes	No	Yes	No

In the past 3 months have you had or do you experience:

A change in your health?	Yes	No
Nausea/Vomiting?	Yes	No
Fever/chills/sweats?	Yes	No
Unexplained weight change?	Yes	No
Numbness or tingling?	Yes	No
Changes in appetite?	Yes	No
Difficulty swallowing?	Yes	No
Changes in bowel or bladder function?	Yes	No
Shortness of breath?	Yes	No
Dizziness?		
Upper respiratory infection?	Yes	No
Urinary tract infection?	Yes	No
Change in your balance (increased falls)	Yes	No

Do you or have you in the past smoked tobacco? Yes No

If yes, _____ packs X ____ Years.
Last tobacco use: _____

Do you drink alcoholic beverages? Yes No
If yes, how many drinks do you routinely have per week? _____/ Week

Date of last physical examination
_____

Circle YES or NO…

Do you have a history of:

Allergies/Asthma?	Yes	No
Headaches?	Yes	No
Bronchitis?	Yes	No
Kidney disease?	Yes	No
Rheumatic fever?	Yes	No
Ulcers?	Yes	No
Sexually transmitted disease?	Yes	No
Seizures?	Yes	No

Are you currently:

Pregnant?	Yes	No
Depressed?	Yes	No
Under Stress?	Yes	No

Are your symptoms: (check one)

Getting worse The same Improving

How are you able to sleep at night? (check one)

Fine Moderate difficulty Only with medication

Do you have a problem with… (check all that apply)

Hearing Speech Vision Communication

My symptoms are worse in the:

Morning Afternoon Evening Night

My symptoms are best in the:

Morning Afternoon Evening Night

List medications currently using:

_____

_____

Patient's Signature:_____