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#: _____

Patient's or Parent/Guardian's email: _____

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 24 hrs. in advance that you will not be in for an appointment). If you miss 3 appointments you may be dismissed from this practice.*
Please initial: _____

PLEASE TELL US HOW YOU HEARD ABOUT US: _____

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

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Patient Name _____ **Date:** _____

Have you RECENTLY noted any of the following (check all that apply)?

❑ changes in your health ❑ weight loss/gain ❑ difficulty swallowing
❑ nausea/vomiting ❑ shortness of breath ❑ pain at night
❑ dizziness/lightheadedness ❑ headaches ❑ balance issues/falls
❑ numbness or tingling ❑ changes in appetite ❑ fever/chills/sweats
❑ changes in bowel or bladder function ❑ urinary tract infection ❑ chest pain

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

❑ cancer ❑ rheumatoid arthritis ❑ diabetes
❑ heart problems ❑ osteoarthritis ❑ stroke
❑ high blood pressure ❑ depression ❑ blood clots
❑ circulation problems ❑ asthma ❑ pacemaker inserted
❑ lung problems ❑ hepatitis ❑ epilepsy
❑ chemical dependency (i.e., alcoholism) ❑ thyroid problems ❑ kidney problems
❑ multiple sclerosis ❑ tuberculosis ❑ liver problems
❑ chest pain/angina ❑ osteoporosis ❑ other_____

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

❑ cancer ❑ diabetes ❑ tuberculosis
❑ heart problems ❑ stroke ❑ thyroid problems
❑ high blood pressure ❑ depression ❑ blood clots

Medications_____

Allergies: _____ Do you smoke? Yes No

What date (roughly) did your present symptoms start? _____

What do you think caused your symptoms? _____

My symptoms are currently: ❑ Getting Better ❑ Getting Worse ❑ Staying the same

Treatment received so far for this problem (chiropractic, injections, etc.) _____

When are your symptoms worst? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise

When are your symptoms the best? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise

Occupation: _____ Leisure activities: _____

Are you depressed? **YES** **NO** Is your depression related to your injury? **YES** **NO**

What is your goal for therapy at this time? _____

I should not do physical activities that might make my pain worse: ❑ Disagree ❑ Unsure ❑ Agree

Patient/Guardian Signature: _____ **Date:** _____