KINDLY GIVE AT LEAST 24 HOURS NOTICE FOR CANCELLATION OR RESCHEDULING. Please be aware to give 24 hours notice or will result in a $50.00 charge ($100.00 for new evaluations). All new patients will be given a phone call the day before their scheduled evaluation to remind them of their appointment.

PLEASE BE TIMELY FOR APPOINTMENTS. If you arrive more than 15 minutes late for your scheduled appointment, you may have to be rescheduled. This is for the benefit of you and the other patients being treated.

WHEN ABLE, PLEASE SCHEDULE YOUR APPOINTMENTS AT LEAST ONE WEEK IN ADVANCE TO ENSURE THE TIMES THAT YOU NEED. Appointment times are given one week do not automatically follow through to the subsequent weeks.

The patient and therapist have discussed the importance of frequency and duration.

THANK YOU FOR YOUR COOPERATION.

___________________________	___________________
Patient Signature	Date

___________________________	___________________
Therapist Signature	Date

PATIENT INFORMATION

Date ____/____/____ Name ____
(First) (Last) (Middle)

Address ______________________________ Apt. # ______________

City ______________________________ State __________ Zip __________

Home Phone ______________ Work Phone __________ Birth Date ______________

Social Security # ______________________ E-Mail ______________________
For updates, seminars, event notices

Marital Status M ☐ S ☐ W ☐ Sex M ☐ F ☐

EMPLOYMENT INFORMATION

Employer / School ______________ Occupation ______________ Dept. __________

Address ____

City ______________________ State ______________ Zip __________

CORE FINANCIAL POLICY

- Patients with health insurance should remember that services rendered are charged to you, the patient, not your insurance company.
- As a courtesy to our patients, we will verify your insurance coverage and benefits (*Verification is only a quote) as well as file therapy claims for you, however we do not accept the responsibility for settling the claim with your carrier.
- If payment is delayed, reduced or denied, you will be responsible for settling your balance with us.
- We require 24-HOUR NOTICE for any cancellation. A $50.00 fee will be charged to your account for failure to comply.

TREATMENT AUTHORIZATION

Your signature is required below to authorize treatment. Your signature also authorizes the release of medical information needed to process your claim, allowing an assignment of benefits where a claim has been filed, and acknowledging your understanding of the above office policies. An additional treatment authorization signature is required by a parent / legal guardian for all minors.

______________________________ ______________
Patient Signature Date

______________________ / ______________________ ______________
Parent or Guardian Signature / Print Full Name Date

HIPAA AUTHORIZATION

In compliance with HIPAA regulations, I authorize the following individuals to receive verbal information regarding the billing of my account.

______________ ______________ ______________
Name / Relationship Name / Relationship Name / Relationship

OUTPATIENT SCREENING FORM

Please answer all questions to the best of your ability.

1. Patient Name:____

2. Age:__________________ 3. Height:________________ 4. Weight:____________________

5. What problem are you being treated for today?________________________________

6. When did your problem begin?________________________________

7. Have you received treatment for these symptoms? *Please check*: Yes No

   If yes, what type? ________________________________

8. Have you received physical/occupational therapy within the last calendar year*? Please check:* Yes No

   If yes, was it for your current problem? *Please check:* Yes No

   Approximately how many treatment sessions have you received this calendar year?____________________

9. Are you currently working? *Please check:* Yes No *Please check:* Light Duty Full Duty Not Working

10. What is your occupation?________________________________

11. Does your occupation consist of: Sitting____ Standing____ Walking____ Lifting____

12. Are you currently taking any medications: *Please check:* Yes No

    If yes, please list medications:________________________________

13. Do you have any known drug allergies? *Please check:* Yes No

    Please list:________________________________

14. Have you had any surgeries or significant past medical history? *Please check:* Yes No

    If yes, please list:________________________________

    ____

    ____

15. What kind of testing have you received for this problem?

    Please check: X-ray MRI CT Scan Bone Scan Other

    If yes, please explain results:________________________________

16. Please place a CHECK next to any conditions that you have experienced in the PAST. CIRCLE any condition that you have CURRENTLY.

- ☐ Bone or joint disease
- ☐ Tendonitis/bursitis
- ☐ Broken/fractured bones
- ☐ Arthritis
- ☐ Spasms/cramps
- ☐ Sprains/strains
- ☐ Low back, hip, leg pain
- ☐ Neck, shoulder, arm pain
- ☐ Headaches/head injuries
- ☐ Jaw pain/TMJ

- ☐ Lupus
- ☐ Aids/HIV
- ☐ Diabetes
- ☐ Seizures
- ☐ Cancer/tumors
- ☐ Heart condition

- ☐ Thyroid problems
- ☐ Lymphedema
- ☐ Kidney problems
- ☐ Irritable Bowel Syndrome
- ☐ Herpes/shingles
- ☐ Sleep disorders
- ☐ Depression
- ☐ Psychological
- ☐ Eating disorder
- ☐ Drug/alcohol addiction
- ☐ Nicotine/caffeine addiction
- ☐ Hypoglycemia
- ☐ Varicose veins
- ☐ Blood clots
- ☐ Breathing difficulties/asthma
- ☐ Sinus problems
- ☐ Chest pain

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Pacemaker
- ☐ Metal Implants

- ☐ Are you pregnant?

- ☐ Rashes
- ☐ Athlete's foot
- ☐ Warts
- ☐ Bladder problems
- ☐ Urinary tract infection
- ☐ Nausea/vomiting
- ☐ Gas/bloating/constipation
- ☐ Allergies/skin allergies
- ☐ Numbness/tingling
- ☐ Fatigue

If you checked/circled any of the above, please explain:______________________________

____

____

____

17. During the past month, have you been bothered by feeling down, depressed, or hopeless?
Please check: Yes No

18. During the past month, have you been bothered by having little interest or pleasure in doing things?
Please check: Yes No

19. Is there anything else we should know that is pertinent to your treatment?______________________

____

20. What is your goal you would like to achieve from therapy?______________________________

____

____

21. Do you exercise regularly? *Please check:* Yes No

If yes, what is your primary activity?______________________________

22. What is your primary language?______________________________

If other than English, will you be providing a translator?______________________________

23. Person to contact in case of an emergency if no one is at your home phone number:

Name:____________________ Phone #:____________________ Relationship:________________

Patient Signature:______________________________________ Date:______________

Signature of Parent/Guardian:______________________________ Date:______________