Patient Questionnaire

Name:____ Date of Birth:_________________

Address:_____________________________________ City:___________________ Zip:________

Cell Phone: ___________________________________ Home Phone: __________________

Email:____

Guarantor Name: ________________________________ DOB:_________ Phone:________________

Employer:____________________________________ Employer Phone:_______________________

Emergency Contact Name:_______________________________________ Relationship:____________

Phone for Emergency Contact:____________________________________

Primary Care Physician: ____

Physician seen for this diagnosis: ____

Regarding the pain for which you are seeking treatment:

Date of injury/ onset of pain: _________________ Diagnosis (if known):_____________________________

Is this injury a work related or caused by a motor vehicle accident? (YES) (NO)

If work related – do you have an attorney? (YES) (NO)

Have you had surgery for this injury? (YES) (NO) Date (if yes):_____________________

How did your symptoms start? ____

Have you received prior treatment for this diagnosis? (ie: chiropractic, orthopedic, massage, primary MD, etc)

____

Have you received prior imaging for this diagnosis? (ie: XRay, MRI, CT Scan, etc)

____

Current Medications (including over the counter and supplements):

____

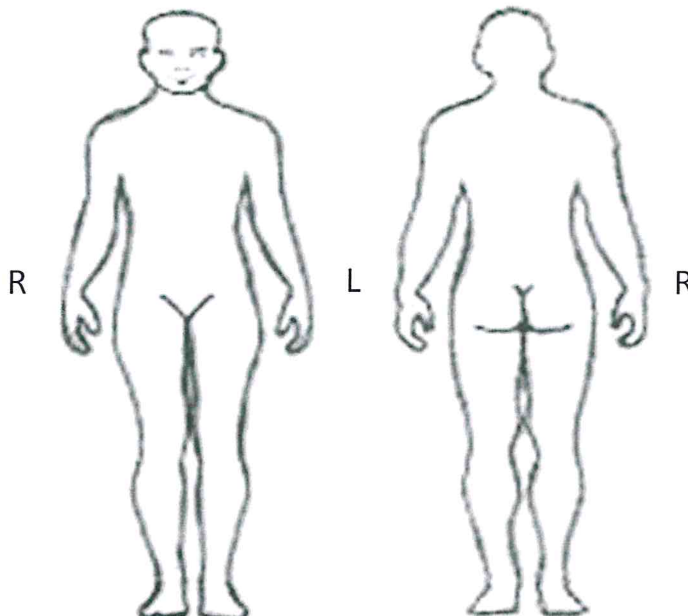
____

Allergies: ____

Rate your pain today:

No pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Mark an X on the body below where you have been experiencing pain/numbness/tingling



Do you have frequent falls? (YES) (NO) Do you live alone? (YES) (NO)

Do you smoke? (YES) (NO)

Height: _______________ Weight: ________________

Are you currently pregnant or think you might be pregnant? (YES) (NO)

Health History/ Past Medical History: Have you EVER been diagnosed with or treated for:

___ Heart Attack : Date___________

___ Congestive Heart Failure

___ Stroke : Date _________________

___ Hypertension

___ COPD

___ Diabetes (Type I or II)

___ Cancer : Type_____________________________

___ Bloodborne Pathogen (HIV, HepC, etc)

___ Autoimmune Disease : Type_____________________

___ Osteoarthritis

___ Rheumatoid Arthritis

___ Other:_________________________________

Appointment Reminders

Please select one of the following for appointment reminders:

___ I do not want reminders

___ Voicemail – call ______________________________________

___ Text ______________________________ (normal text messaging rates apply)

___ Email ____

Release of Information

I authorize the release of medical and claim information to:

Spouse: ____________________________________ Child(ren): ___________________________________

Other: ____

___ Mark this line if you do not want information to be released to anyone

This release of information will remain in effect until terminated by me in writing:

Patient/Guardian Signature: ____ Date: ___________

Cancellation/ No Show Policy

Please initial the following statements

___ We cannot guarantee that a patient will be seen if they are more than 15 minutes late. *Your session will be reduced* by that amount of time so that the therapist can be mindful of the next patient on their schedule.

___ A $50.00 charge will be assessed for no shows and may be assessed for cancellations made same day.

___ If you have 3 consecutive no shows we will discharge your case and notify the referring provider and insurance company.

Benefit Assignment/ Release of Information

I hereby authorize release of information necessary for my insurance company to process my claim. The above information is correct to the best of my knowledge. I hereby authorize payment of insurance benefits directly to Physio Therapy Professionals. I understand that I am financially responsible for charges denied by my insurance. A photocopy of assignment is to be considered as valid as original.

I have read the above information and certify that I understand and will abide by the policies set forth by Physio Therapy Professionals. I do hereby agree and give my consent for Physio Therapy Professionals to furnish medical treatment considered necessary and proper in diagnosing or treating my/my child's physical condition.

Patient's Name (Print): ____

Patient/ Guardian Signature: ______________________________________ Date:____________

Witness: ______________________________________ Date: ____________

Financial Policy Statement

Please initial the following statements and sign at the bottom

Physio Therapy Professionals will bill your insurance carrier. Once the Explanation of Benefits is received in our office, if there is an outstanding balance it will be billed and mailed directly to you at the address you provided. You are responsible for payment after the services are rendered.

____ It is the responsibility of the patient/guardian to pay all copays and self-pay amounts at the time of service.

____ I agree to assign all medical benefits to Physio Therapy Professionals for services provided.

____ It is my responsibility to pay any uncovered services and balances within 30 days of receiving the bill.

____ Past due balances must be paid prior to receiving additional services.

____ In the event that my insurance DENIES payment, I will be responsible for payment for services provided.

____ If I fail to make payments for which I am responsible in a timely manner, I will be responsible for all costs associated with collection of monies owed, including recovery of court costs, collection fees, and attorney fees as well as interest of 1% per month on outstanding balances.

____ Returned checks will result in a $50.00 service charge.

____ In the event of an overpayment and a refund if required, the refund will be issued by check and mailed to the last known address. Please allow 30 days for processing.

Patient's Name (Print): ____

Patient/Guardian Signature: ______________________________________ Date: ____________

Witness: ______________________________________ Date: ____________