

PATIENT NAME: **FIRST**_____ **MI**____ **LAST**_____

DATE OF BIRTH_____ **SSN**_____ **MALE**_____ **FEMALE**_____

STREET ADDRESS_____ **APT#**_____

CITY_____ **STATE**_____ **ZIP CODE**_____

MAILING ADDRESS IF DIFFERENT_____

HOME PHONE_____ **CELL PHONE**_____ **EMAIL**_____

EMPLOYER_____ **PHONE**_____

ADDRESS_____ **CITY**_____ **STATE**_____ **ZIP**_____

SPOUSE'S NAME_____ **CELL PHONE**_____ **WORK PHONE**_____

EMPLOYER_____ **PHONE**_____

ADDRESS_____ **CITY**_____ **STATE**_____ **ZIP**_____

EMERGENCY CONTACT_____ **RELATIONSHIP**_____ **PHONE**_____

REFERRING PHYSICIAN_____ **PHONE**_____

LAST DATE SEEN_____ **NEXT PHYSICIAN VISIT**_____

FAMILY PHYSICIAN_____ **PHONE**_____

ACCIDENT RELATED INJURY? YES___ **NO**___ **DATE OF ACCIDENT**_____

HOW DID YOU HEAR ABOUT US? □REFERRING PHYSICIAN □FAMILY □FRIEND □ATHLETIC TRAINER □OTHER_____

PRIMARY INSURANCE:_____ PHONE_____
INSURED'S NAME:_____ SS#_____ DOB_____
EMPLOYER:_____ PHONE_____
RELATIONSHIP TO THE INSURED _____

SECONDARY INSURANCE:_____ PHONE_____
******A $10.00 FEE WILL APPLY TO FILE YOUR SECONDARY (DOES NOT APPLY TO MEDICARE)***
INSURED'S NAME:_____ SS#_____ DOB_____
EMPLOYER:_____ PHONE_____
RELATIONSHIP TO THE INSURED_____

_____ _____
PATIENT SIGNATURE OR GUARDIAN IF A MINOR **DATE**

MEDICAL HISTORY

Please answer the following questions as applicable and sign the bottom of this form.

Heart Disease
□ Heart Attack
□Arteriosclerosis
□Rheumatic heart disease
□Heart murmur
□CHF
□Pacemaker/Defibrillator

Lungs
□Asthma
□Emphysema
□Turberculosis
□Shortness of Breath

Muscle Conditions
□Carpal Tunnel
□Tennis Elbow
□Back Problems
□Neck Problems

Blood Pressure
□Normal
□High
□Low

Other Conditions
□MultipleSclerosis
□Epilepsy/seizures
□Gout
□Lupus
□Sprains/Fractures
□Osteoporosis
□Cancer
□Hepatitis
□Diabetes
□Rheumatoid Arthritis
□Polio
□Night sweats/unexplained fevers
□Fainting
□Hearing loss
□Depression

□**Other conditions not listed above**: _____

- **Female Patients:** Are you pregnant? □Yes □No
- **Tobacco User: □ Yes □ No**
- **List known allergies:** _____ □ None
- **List any prior injuries:** _____□ None
- **List any current injuries:** _____ □ None
- **List any prior surgeries**: _____

  _____ □ None
- **Please list any medications, including over the counter, you are currently taking (include pills, injections and or skin patches):** _____

  _____ □ None
- **Have you had physical therapy, speech therapy or chiropractic treatment *in the current year*? If yes, please explain:** _____
- **Are you currently receiving Home Health services (nursing, therapy, other)?** □Yes □No
- **Have you fallen 2 or more times in the past year?** □Yes Date(s) of Fall(s)_____ □No

PATIENT SIGNATURE OR GUARDIAN IF A MINOR **DATE**



CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

The undersigned acknowledges receipt of a copy or viewing of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT RECORDS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____

Please ***print*** your name Please ***sign*** your name

_____ _____

Legal Representative Description of Authority

Your comments regarding Acknowledgements or Consents:

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Sir Name ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS,** VIA THE EMAIL LISTED BELOW:

☐ Email: _____

☐ I do not have an email address.

I AUTHORIZE **INFORMATION ABOUT MY HEALTH**, **TREATMENT & BILLING INFORMATION** BE CONVEYED VIA:

☐ Cell Phone Confirmation ☐ Email: _____

☐ Home Phone Confirmation ☐ Work Phone Confirmation ☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message ☐ Text Message ☐ Email ☐ **None of the above**

_____ _____

Patient Signature or Guardian if a minor Date

PATIENT CONSENT

FINANCIAL RESPONSIBILITY AND COMMUNICATION CONSENT

By signing below, I acknowledge and understand that I am financially responsible for all services provided by Dosher Physical Therapy Associates that are not covered by my insurance plan, including services denied as non-covered, excluded, or determined by my insurance company to be not medically necessary.
I understand that insurance coverage information provided before treatment is only an estimate, and Dosher Physical Therapy Associates may not know whether a service will be covered until my insurance company completes its review and processing of the claim.
I authorize Dosher Physical Therapy Associates to contact me at any telephone numbers provided, including mobile phone numbers, regarding my account, billing questions, outstanding balances, or payment arrangements. I understand that this authorization includes communication from an outside collection agency if my account is referred for collection due to an unpaid or delinquent balance.

I have read and understand my financial responsibilities. **Initials**: ____

CONSENT FOR TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION

I consent to evaluation and treatment by Dosher Physical Therapy Associates as recommended by my healthcare provider and understand that no guarantee or assurance has been made regarding the outcome or results of treatment.
I authorize Dosher Physical Therapy Associates to release and obtain relevant health information necessary for my care, treatment, payment, and healthcare operations. This may include communication with my insurance company, referring physician, employer (when applicable), and other healthcare providers or authorized third parties involved in my care. Initials: ____

BENEFIT ASSIGNMENT: I hereby authorize payment be made directly to Dosher Physical Therapy Associates. If my insurance company should require that payment be made to me, I will in turn issue payment to Dosher Physical Therapy Associates for any charges that I have not previously paid and/or charges that are not covered by my insurance company. **Initials: _____**

PATIENT ACKNOWLEDGEMENT OF RECEIPT OR REQUEST OF NOTICE OF PRIVACY PRACTICES

Dosher Physical Therapy Associates' Notice of Privacy Practices is available upon request. This notice explains how your protected health information (PHI) may be used and disclosed, including for treatment, payment, healthcare operations, quality improvement, and administrative purposes.
I understand that I have the right to request restrictions on the use and disclosure of my PHI. Dosher Physical Therapy Associates will consider such requests; however, the practice is not required to agree to requested restrictions.
I consent to the use and disclosure of my PHI as described in the Dosher Physical Therapy Associates Notice of Privacy Practices. I understand that I may revoke this consent at any time by providing written notice to the practice.
I acknowledge that I have been provided with the opportunity to review or request a copy of the Notice of Privacy Practices and understand my rights regarding the use and disclosure of my health information under applicable HIPAA regulations**. Initials: ____**

Patient Signature or Guardian:_____ Date: _____