

**PhysioCare**  
PHYSICAL & OCCUPATIONAL THERAPY  
**PATIENT INFORMATION**

Date: \_\_\_\_\_

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Local Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ Work / Cell #: \_\_\_\_\_

Permanent Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Gender: M  F  E-mail: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_ Occupation: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Specialist: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

Whom may we thank for referring you to us?  
\_\_\_\_\_

Who is responsible for this bill? \_\_\_\_\_

Are you currently employed? \_\_\_\_\_ Are you covered under an employer or union health plan? \_\_\_\_\_

Did you sustain an injury while at work? \_\_\_\_\_ Are your injuries accident related? \_\_\_\_\_

I will be paying today by cash: \_\_\_\_\_ check: \_\_\_\_\_ credit card: \_\_\_\_\_

*I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent ( if minor)

\_\_\_\_\_  
Date

**I have received the HIPPA Privacy Notice**  
\_\_\_\_\_  
Signature

**All patients will be charged a \$25.00 no-show fee if a 24 hr. notice of cancellation is not received for visits.**  
\_\_\_\_\_  
Signature



TREATMENT AUTHORIZATION

MEDICARE ACKNOWLEDGEMENT

Medicare law requires us to make you aware that the patient will be billed for the rehabilitation services. Medicare assignment is accepted on all patients. Medicare will pay for reimbursable charges on rehabilitation services at 80%. We will bill your co-insurance, or we will bill you, for the 20%. Outpatient therapy services are billed under the Medicare fee schedule, Private Insurance Fee Schedule, or our customary Fee Schedule. We will verify all private insurance company benefits. You will be responsible for all co-pays and deductibles cost as outlined by your insurance company.

I. Financial Agreement

I understand the financial responsibility for treatment. My insurance policy will pay for my treatment, cost and charges but in the event they deny or deductible payment, I am responsible for the balance not covered by my insurance policy.

(Initials) I hereby authorize payment directly to Physiocare, Inc.

II. Consent to Receive Services

(Initials) I hereby authorize Physiocare, Inc. to render appropriate services as prescribed by my Physician, or any other Physician who may be treating me, including all diagnostic and therapeutic treatment that may be considered advisable or necessary in judgment of the physician.

III. Medical Insurance Benefit Form

(Initials) I authorize any holder of medical or other information about the patient to release to the Social Security Administration or its intermediaries or carriers copies of any information to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

(Initials) I authorize any physician, hospital or medical specialist who has treated me in the past, present or future to release information regarding my medical condition.

(Initials) I authorize to receive information regarding my medical condition, health, treatment, financial, or any other personal information.

Patient

Date

Witness

Date

POA/Guardian Verbal Consent Verification (verbal consent must be followed by written confirmation)

Power of Attorney/Guardian

Relationship

Address

City

State, Zip

I give permission for to be evaluated for P.T. or O.T. Permission is granted to bill primary insurance and any secondary insurance, or to bill directly if there is no secondary insurance.

POA/Guardian Signature

Date

PATIENT INFORMATION

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date \_\_\_\_\_

MEDICAL/SURGERY HISTORY

Circle all that apply: Arthritis Blood Pressure High / Low Breaks/Fractures Cancer Diabetes  
Head Injury Heart Conditions Pacemaker / Defibrillator Circulatory Problems  
Osteoporosis MS MD Parkinson's Seizure / Epilepsy Neuropathy  
Headache / Migraine Joint Replacement HIP / KNEE / SHOULDER  
OTHER \_\_\_\_\_

Vertigo / Dizziness Loss of Balance / Falls Shortness of Breath Difficulty Sleeping  
Changes in Bowel / Bladder Control Vision Problems Hearing Loss Ringing in Ears  
Coordination Problems Unexplained Weight Loss Difficulty Walking Swelling

Recent or Major Surgeries (include dates) \_\_\_\_\_  
\_\_\_\_\_

Reason for seeking Physical Therapy / Occupational Therapy treatment: \_\_\_\_\_  
\_\_\_\_\_

How do you rate your pain level on a 0-10 Scale? (0 is no pain and 10 is the worst pain) \_\_\_\_/10

Have you had treatment for this problem in the past? YES / NO

Type of treatment: \_\_\_\_\_

Are you currently receiving treatment through Home Health Care? YES / NO

HOME:

Circle all that apply: Stairs Handrails R / L Carpeting Tile / Wood Flooring Throw Rugs  
Ramps Safety Bars Location of Safety Bars \_\_\_\_\_

Others living in the home \_\_\_\_\_

FUNCTIONAL LIMITATIONS: Walking Tolerance \_\_\_\_\_ minutes  
Standing Tolerance \_\_\_\_\_ minutes Sitting Tolerance \_\_\_\_\_ minutes

Activities you are currently unable to perform or have difficulty with: (Mark U for Unable, D for Difficulty)  
\_\_\_\_ Driving \_\_\_\_ Backing car out \_\_\_\_ Working \_\_\_\_ Household Chores \_\_\_\_ Lifting  
\_\_\_\_ Reading \_\_\_\_ Writing \_\_\_\_ Sitting \_\_\_\_ Standing \_\_\_\_ Walking \_\_\_\_ Computer Work  
\_\_\_\_ Reaching Overhead \_\_\_\_ Reaching Behind Back \_\_\_\_ Kneeling \_\_\_\_ Bending \_\_\_\_ Gardening  
\_\_\_\_ ADL's (bathing, grooming, hygiene) \_\_\_\_ Dressing \_\_\_\_ Shoes & Socks (ON / OFF)  
\_\_\_\_ Getting out of chair \_\_\_\_ Getting out of car \_\_\_\_ Getting in to / out of Bed  
\_\_\_\_ Sports (list all sports that apply) \_\_\_\_\_

Do you have any allergies?

Medicines \_\_\_\_\_

Latex \_\_\_\_\_

Other \_\_\_\_\_