



Confidential Medical History/Evaluation

Name: _____ Date: ____/____/____ Referring MD: _____

Address (Full): _____ Date of Birth: ____/____/____

SS#: _____ Phone: _____ Cell phone: _____ Work phone: _____

Name of Policyholder: _____ Policyholder's DOB: _____ Patient – Status: Married / Single / Other

Insured Employer/Address: _____ Phone: _____

Occupation: _____ Is this injury? Work Related _____ Auto Accident _____ (If so, in what state) _____

Chief Complaint: _____ Date of Injury: _____

Current Symptoms: Pain / Numbness /Stiffness Weakness Condition: New / Acute / Chronic

List any/all medications you are currently taking: _____

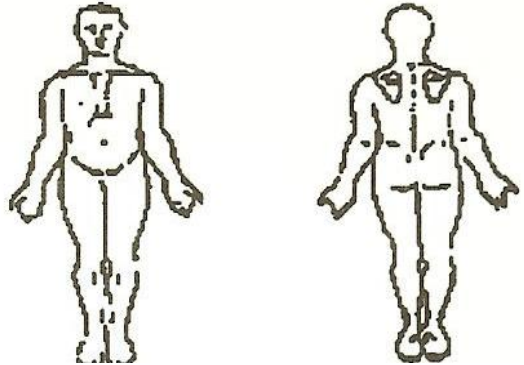
Are you allergic to any medications? _____

List any surgeries: _____

Do you have any of the following?

	YES	NO
Asthma, Bronchitis or Emphysema	_____	_____
Shortness of Breath/Chest Pain	_____	_____
Coronary Heart Disease	_____	_____
Do you have a Pacemaker	_____	_____
High Blood Pressure	_____	_____
Heart Attack/Surgery	_____	_____
Stroke/TIA	_____	_____
Blood Clot/Emboli	_____	_____
Epilepsy/Seizures	_____	_____
Thyroid Trouble/Goiter	_____	_____
Anemia	_____	_____
Infectious Disease	_____	_____
Diabetes	_____	_____
Cancer or Chemo/Radiation	_____	_____
Arthritis/Swollen Joints	_____	_____
Osteoporosis	_____	_____
Varicose Veins	_____	_____
Gout	_____	_____
Sleeping Difficulties	_____	_____
Emotional/Psychological Problems	_____	_____
Bowel or Bladder Problems	_____	_____
Severe/Frequent Headaches	_____	_____
Vision/Hearing Difficulties	_____	_____
Dizziness or Faintness	_____	_____
Pins/Implants/Rods	_____	_____ I
Are you pregnant?	_____	_____

Indicate on Diagram where the pain is:



Pain Scale – Circle (10 Being the worst) 1 2 3 4 5 6 7 8 9 10

Other Medical Conditions: _____

Are you aware of your Diagnosis? YES _____ NO _____

Are you aware of your Prognosis? YES _____ NO _____

Have you had any Diagnostic or Rehabilitative Services for this Injury?
MRI X-rays Other: _____

Emergency Contact: _____ Phone #: _____

I acknowledge that I have seen the “Notice of Privacy Practices.” I understand that I may ask questions about the “Notice of Privacy Practices” at any time.

Patient/Parent/Guardian Signature: _____ Date: _____

I hereby agree and give my consent to medical treatment in treating my physical condition. I authorize release of any medical information needed to process my claim. I understand that I am responsible for any charges that are not covered by my insurance carrier. Furthermore, I understand that I am responsible to inform the office of any changes that occur. I authorize release of payment directly to State Of The Art Physical Therapy regardless of participation in or out-of-network. Should I default on my financial responsibility and collection action is necessary, I will be responsible for collection costs that Self Pay patients – Payment is due upon services being rendered.

Patient/Parent/Guardian Signature: _____ Date: _____

FEE FOR NON-REIMBURSABLE SUPPLIES

Electrical stimulation is a treatment modality that may be recommended by your physical therapist. It is a modality that is used to help manage pain and increase circulation. Insurance will not cover the cost of certain supplies necessary to perform electrical stimulation as suggested by your therapist. If electrical stimulation is suggested, there will be a onetime fee charge of \$7.00 billed to your account, for the supplies that will be used each time you will receive this treatment modality. Please indicate below if you accept or deny the modality.

(Patients with PACEMAKERS are not eligible for Electrical stimulation)

- Yes, I would like the physical therapist to provide this modality if recommended and understand that I will be charged a onetime fee of \$7.00 for the supplies utilized in electrical stimulation.

- No, I wish to defer the utilization of electrical stimulation and will not be charged the onetime fee.

Iontophoresis is a treatment modality that may be recommended by your physical therapist. It is a modality that helps to significantly decrease localized inflammation. Insurance will not cover the cost of certain supplies necessary to perform iontophoresis as suggested by your therapist. If iontophoresis is suggested by your physical therapist your account will be charged an \$8.00 fee for every iontophoresis patch that is utilized in your treatment. Please indicate below if you accept or deny the modality.

(Patients with PACEMAKERS are not eligible for Iontophoresis)

- Yes, I would like the physical therapist to provide this modality if recommended and understand that I will be charged a fee of \$8.00 for each iontophoresis patch used.

- No, I wish to defer the utilization of iontophoresis in my treatment.

Patient / Legal Guardian Signature

Date

No Show / Cancellation Policy

Please be advised that State of The Art Physical Therapy has a No Show / Cancellation policy which will be enforced. We understand that emergencies arise, but we as a business allocate specific dates and times for our patients, so we may offer the utmost professional care possible to our patients.

Cancellations: Should you need to cancel, we request you do so by informing State of The Art Physical Therapy at least 24 hours prior to your scheduled appointment. Should you fail to inform State of The Art Physical Therapy within the timely manner, a \$25.00 cancellation fee may be charged to your account.

No-Show: No-Show fees will be charged at a rate of \$50.00 per incident to your account.

State of The Art Physical Therapy reserves the right to reschedule patients who arrive late.

I accept the No-Show / Cancellation policy and agree to adhere to it:

Patient / Legal Guardian Signature

Date