



Welcome! Please fill out as much information as possible. If you have any questions or need any assistance please ask the receptionist. Thank you! **(AUTO ACCIDENT)**

Confidential Patient Information

Name(First, Middle, Last):		What do you prefer to be called?	Date
Street Address:		City/State	Zip Code
Home Phone: ()	Work Phone ()	Cell Phone/Pager ()	
Email Address:	Date of Birth	Current Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Social Security #:			

Health Insurance Information:

Name or Insurance Company	Billing Address	Policy # and Subscriber
Phone #: ()		
Name of Insured	Relationship to insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child	Insured's Employer

Auto Insurance Information

Name or Insurance Company	Billing Address	Policy # and Subscriber
Phone #: ()		
Name of Insured	Claim # Date of Injury: _/_/_	Claims Adjuster Phone #: ()

Attorney Information

Name of Attorney	Street Address, City, State and Zip Code	Phone # Fax #
------------------	------------------------------------------	----------------------

How were you referred to us?

<input type="checkbox"/> Patient Name:	<input type="checkbox"/> Physician Name	<input type="checkbox"/> Other
----------------------------------------	-----------------------------------------	--------------------------------

Primary Care Physician name:	Phone #: ()
-------------------------------------	---------------------

Work Status: Employed Retired Disabled Full-time Student Part-time Student

Employer Phone #: ()	Occupation and Job Responsibilities	
Employer Address	City/State	Zip Code

Marital Status: Married Single Divorced Separated Widowed Spouse's Name _____

Primary Language Spoken _____ **Hand Dominance:** Left Right Ambidextrous N/A

CONSENT OF TREATMENT OF A MINOR

I hereby authorize Jon Dooley, MSPT and whomever he may so designate as his assistant, to administer physical therapy care as he deems necessary to my son/daughter, _____, dated _____, 20____ at Greendale Physical Therapy.

Signature:

Witnessed:

IN CASE OF EMERGENCY

Who should we contact?	Relation
Home Phone:	Work Phone:
	Cell Phone:

Accident Information

Date of Accident?	Was the accident reported? <input type="checkbox"/> Yes <input type="checkbox"/> No When?
Where did the accident occur? Street/Town etc.	
Details of the accident	
Please list the symptoms you felt immediately after the accident?	
Please describe the pain and its location.	
What is the intensity of your symptoms? <input type="checkbox"/> Slight <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Emergency	
How often do you experience these symptoms? <input type="checkbox"/> Constant <input type="checkbox"/> Frequent (75% of day) <input type="checkbox"/> Often (50%) <input type="checkbox"/> Seldom (25%) <input type="checkbox"/> Rarely (less than 25%)	
What makes your symptoms worse?	
What makes your symptoms better?	
Is the condition interfering with your: <input type="checkbox"/> Sleep <input type="checkbox"/> Work <input type="checkbox"/> Daily Routine If so, Explain:	
Where you wearing a seat belt? <input type="checkbox"/> Yes <input type="checkbox"/> No	Where were you located in the vehicle? <input type="checkbox"/> Driver <input type="checkbox"/> Front seat passenger <input type="checkbox"/> Other_____
Where were you taken after the accident?	Where you taken to the Hospital by <input type="checkbox"/> Ambulance <input type="checkbox"/> Private Vehicle <input type="checkbox"/> Other_____
Where X-ray taken? <input type="checkbox"/> Yes <input type="checkbox"/> No	MRI? <input type="checkbox"/> Yes <input type="checkbox"/> No Catscan? <input type="checkbox"/> Yes No
Give the dates you missed work as a result of the accident.	
Additional Information:	
Have you sought any other treatment for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If so, where and by whom?	
Have you been treated by a physical therapist before? <input type="checkbox"/> Yes No	
If so, where and by whom?	

Do you regularly exercise or work out? Yes No If so, how often?

Health History

Are you taking any of the following medications:

- Nerve pills Non prescription pain killers Muscle relaxes Stimulants
- Blood thinners Tranquilizers Insulin Other _____

Please list any previous surgeries, serious traumas, or serious accidents, include dates if known.

- 1. _____ Date _____
- 2. _____ Date _____
- 3. _____ Date _____

Do you have, or have you ever had, any of the following diseases or conditions? Check all that apply:

- No Past Medical History Emphysema/Glaucoma Multiple Sclerosis Alcohol/Drug Abuse
- Fainting/Seizures/Epilepsy Muscular Dystrophy Anemia Frequent Neck Pain
- Osteoporosis Arthritis Heart Surgery/Pacemaker Frequent Headaches
- Blood Disorder Hepatitis Shingles Cancer
- High/Low Blood Pressure Sinus Problems Chemotherapy HIV+/AIDS
- Tuberculosis Circulation Problems Kidney Problems Ulcers/Colitis
- Currently Pregnant Liver Disease Diabetes Lower Back Problems
- Difficulty Breathing Mitral Valve Prolapse Other _____ Other _____

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform the office of any changes to the information I have provided.

Signature: _____ Date _____

FINANCIAL AGREEMENT

GREENDALE PHYSICAL THERAPY accepts third party billing. We will send your insurance claims to the address provided, on a weekly basis. **It is your responsibility** to call your insurance company to check on the coverage provided by your individual policy.

Most insurance companies require a doctor’s referral, if this is the case with your policy; you should have your physician forward the referral to our office.

Medicare requires that you have an appointment with your physician every 30 days to be reviewed and re-certified.

If we have not received payment from your insurance company within 30 days, we expect payment from you directly. Your insurance contract is between you and your carrier. We submit claims as a courtesy to you. **You are directly responsible for your payment of our services.** Occasionally, insurance companies may not cover certain physical therapy treatment procedure (such as, but not limited to, iontophoresis, massage, and ultrasound). If your insurance will not pay for these procedures you can choose to pay for that procedure yourself or you can decline the procedure in question. The choice is always yours. If you are unsure whether or not a procedure is covered it is your responsibility to find out. There are numerous policies and each is different so **we cannot advise you about your coverage.**

Our fees are generally considered to fall within the acceptable range by most insurance companies, and therefore are covered up to the maximum allowable determined by each carrier. This applies to companies who pay a percentage of usual, customary, and reasonable fees (UCR). Thus, most insurance companies consider our fees usual, customary, and reasonable.

This statement does not apply to all companies who reimburse based on arbitrary “schedule” of fees, which bears no relationship to the current standard and cost of care in this area.

***GREENDALE PHYSICAL THERAPY RESERVES THE RIGHT TO CHARGE A FEE OF \$25
FOR MISSED APPOINTMENTS THAT ARE NOT CANCELLED.***
THIS CHARGE WILL BE TO YOU, THE CLIENT OR RESPONSIBLE GUARDIAN, NOT YOUR INSURANCE COMPANY.

WE ALSO RESERVE THE RIGHT TO REFUSE TREATMENT FOR ANY CLIENT THAT HAS FAILED TO SHOW FOR THREE OR MORE APPOINTMENTS.

For **account in litigation**, we will bill your health/auto insurance directly. Please be advised that **you are responsible** for payment of your bill, not the individual being sued. Liability action against someone else will not enable you to refuse payment to us.

We do require a lien on your settlement (a promise to pay), which it is ultimately the patient’s responsibility to sign and file with their attorney (If applicable), and return to our office within one week after starting physical therapy. To expedite the process, GPT may on your behalf forward these documents to your attorney. However, in the event that we are not able to obtain a signed lien, the patient will be notified to pursue and file the said lien with their lawyer.

If you would like to submit your own claims to your insurance company, we will require payment at the time of the treatment.

*****Patients with a co-pay are required to make payment at the time of treatment.*****

If during the course of treatment your insurance company changes, **please** let us know **immediately**.

If you have any questions, please feel free to ask the receptionist.

Signature: _____ Date: _____