TRI-COUNTY PHYSICAL THERAPY INSTITUTE
HANDS-ON SPECIALITY CARE

PATIENT INFORMATION

Name: _____ (First, MI, Last) DOB: _____/_____/_____

Address: _____ City: _____ State: _____ Zip: _____

Phone:_____ Phone:_____ Email:_____

□ Home □ Cell □ Work □ Home □ Cell □ Work

Would you like a reminder email about your scheduled appointment times? □Yes □ No

TREATMENT INFORMATION

Reason for treatment: _____ Date of injury/surgery: _____

Referring Physician: _____ City/State: _____

Primary Care Physician: _____ City/State: _____

Other Consulting Physician: _____ City/State: _____

Have you previously received any PT, OT, speech therapy, or chiropractic care in this calendar year? □Yes □ No

Are you current receiving home healthcare? □Yes □ No

INSURANCE INFORMATION

We will need a copy of your driver's license and most recent insurance card(s).

Primary Insurance: _____ Secondary Insurance: _____

For Auto Accident or Worker's Comp. patients:

Is condition related to: □Work □ Auto Accident (State: _____) Injury date/info:_____

Do you have a lawyer? □Yes □ No If yes, please provide lawyer contact information: _____

CONTACT INFORMATION

I authorize Tri-County Physical Therapy Institute, LLC, to release my medical information to the following individual(s) (spouse, parent, child, relative, friend, etc.)

Name: _____ Relation: _____

Name: _____ Relation: _____

HIPAA: By signing this form I acknowledge that I have access to the HIPAA "Privacy and Security Regulations Procedure Model" from **Tri-County Physical Therapy Institute, LLC** ("**PTI**"), displayed in the lobby, and I understand it completely.

CONSENT: By signing this form, I agree and give my consent for **PTI** to furnish physical therapy care and treatment considered necessary and proper in diagnosing and/or treating my physical condition. I authorize **PTI** to release my medical records to my insurance and my physician(s). I recognize I have the right to decline any portion of my treatment at any time. I acknowledge the health and personal information above is true to the best of my knowledge.

FINANCIAL POLICY: By signing this form, I agree to the following financial policy: **PTI** will bill my primary insurance and, if applicable, bill my secondary insurance after my primary insurance has paid. I agree to pay any portion of the charges not covered by my insurance. Copayments are due at the time of service and co-insurance will be billed after my insurance processes the claim. For large deductibles (over $300), **PTI** requires a $50 deposit per visit at the time of service. A fee of $15 may be charged for appointments cancelled with less than 24 hours notice. I assign all medical benefits to **PTI** including health insurance, Medicare, auto insurance, worker's compensation or other insurance plans. I authorize **PTI** to release all information necessary to secure payment. **PTI** accepts accept VISA, MasterCard, Discover, American Express, personal checks and cash. There is a fee of $25 for any checks returned by my bank. If my account is past due and **PTI** refers my account to a collection agency, a surcharge of 30% will be added to my balance. If **PTI** must refer collection of the balance to a lawyer, I agree to pay all lawyers' fees which **PTI** incurs plus all court costs.

SELF-PAY OPTION: You have the option to personally pay for your physical therapy evaluation and treatment. Once you have chosen private pay, we will not bill your insurance carrier for services rendered. If payment is not paid at the time of service, you will be billed a $15.00 administrative fee in addition to the treatment charge. The private pay rate is as follows: Initial Evaluation: $110.00. Subsequent treatments for the same diagnosis: $60.00. Please initial here for self-pay option_____

Signature : _____ Date : _____

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Medical History

In the past 12 months:

How many times have you fallen?_____ If you HAVE fallen, how did this occur?:_____

If you injured yourself in the fall, describe injury:_____

Please mark all that apply:

Do you have a history of:		Do you have a history of:		In the past 3 months did you have/experience:	
Allergies/Asthma?	☐	Osteoporosis?	☐	A change in your health?	☐
Angina/Chest Pain?	☐	Parkinson's?	☐	Nausea/Vomiting?	☐
Bronchitis?	☐	Rheumatoid Arthritis?	☐	Fever/chills/sweats?	☐
Cancer?	☐	Seizures?	☐	Unexplained weight change?	☐
Dementia?	☐	Strokes?	☐	Numbness or tingling?	☐
Diabetes?	☐	Ulcers?	☐	Changes in appetite?	☐
Headaches?	☐	Bloodborne illness?	☐	Difficulty swallowing?	☐
High Blood Pressure?	☐	**Are you currently:**		Changes in bowel or bladder function?	☐
Infections?	☐	Pregnant?	☐	Shortness of breath?	☐
Kidney Disease?	☐	Depressed?	☐	Dizziness?	☐
Osteoarthritis?	☐	Under stress?	☐	Upper respiratory infection?	

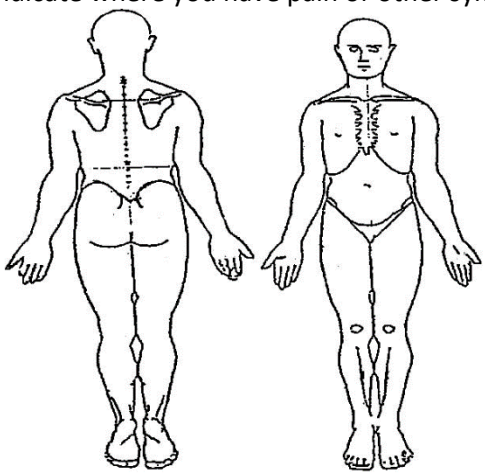
Have you ever had an X-Ray, MRI or other imaging study? _____ Date (MM/YYYY):_____

Date of last Physical Examination:_____ List medications currently using:_____

_____

Current Condition

Indicate where you have pain or other symptoms:



Please circle the number that best represents your level of pain

Pain when you are feeling best:

None 1 2 3 4 5 6 7 8 9 10

Pain when you are feeling worst:

None 1 2 3 4 5 6 7 8 9 10

Current Pain:

None 1 2 3 4 5 6 7 8 9 10

Please circle activities which make your pain worse:

SITTING STRESS LYING DOWN WALKING STANDING

Other:_____

Please list the best and worst time of the day for your symptoms:

Best:_____ Worst:_____

Identify important activities that you are unable to do or are having difficulty doing as a result of your problem:

_____

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Tri-County Physical Therapy Institute is now providing appointment reminders via text and/or email alerts. If you would like to be added to receive emails and/or text alerts, please provide your information below.

Yes, I would like to be added to receive appointment reminders. ☐

Yes, I would like to be added to receive event reminders and newsletter information. ☐

Name:

_____

Email:

_____

Phone:

_____