

**PATIENT INFORMATION**

Today's Date \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_ Apt \_\_\_\_\_

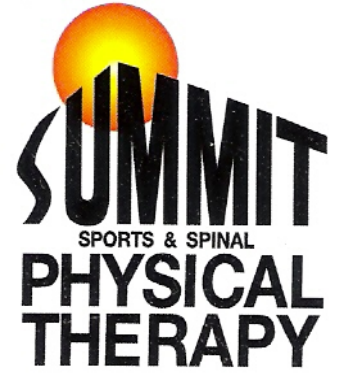
City \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Gender M / F

Cell Phone \_\_\_\_\_ Marital Status

SS # \_\_\_\_\_ M / S / D / W

Email (optional) \_\_\_\_\_



**EMERGENCY CONTACT INFO (Required)**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

**Would you like a CONFIRMATION CALL the day before each of your appointments? YES / NO**

(Please note Cancellation/No-Show Policy below) **Which number?** Home / Cell / Work / Other \_\_\_\_\_

**WORK STATUS** Full Time / Part Time / Retired / Not Employed Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

**INJURY INFO** Injury Location \_\_\_\_\_ Injury Date \_\_\_\_\_ Surgery Date \_\_\_\_\_

Cause of Injury: Auto Accident / Work Related / Sports / Other \_\_\_\_\_

How did you hear about us? Doctor / Friend/Relative / Phonebook / Internet / Other \_\_\_\_\_

Name of Doctor who referred you: \_\_\_\_\_

**MEDICARE PATIENTS:** Within this year, have you received / been receiving **Home Health Care?** Y / N \_\_\_\_\_

If you answered yes, provide a timeframe: **Dates** \_\_\_\_\_ til \_\_\_\_\_ (INITIALS)

**HEALTH HISTORY (Please circle all that apply)**

Irregular Heart Beat    Asthma    Osteoporosis    Smoker    Diabetes, Type \_\_\_\_\_

Chronic Bronchitis    Cancer    Emphysema    Heart Valve Problem    Insulin / Glucose

Pacemaker    Arthritis    Hay Fever    High Blood Pressure    Gastrointestinal Disorder

Heart Surgery    Bleeding Disorder    Angina    Other Problems, Surgeries or Broken Bones:

Heart Attack    Kidney Disorder    Seizures    \_\_\_\_\_

**CANCELLATION / NO SHOW POLICY**

Please call our office with at least **24 hours notice** if you need to cancel or change your appointment. You will be responsible for a **\$25 Cancellation Fee** after each cancellation UNLESS you reschedule for the same or NEXT day.

I am aware of Summit's cancellation policy:

Signature \_\_\_\_\_ Date \_\_\_\_\_

**FINANCIAL RESPONSIBILITY**

I assign all medical benefits and authorize my insurance carrier(s) to issue payment directly to Summit Sports & Spinal Physical Therapy and/or my Therapist. I understand that Summit will bill my insurance carrier(s) directly for services rendered. However, if the insurance carrier(s) should deny responsibility for these claims, I understand I will be held responsible. Failure to pay bills in a timely manner will result in a 40% account increase to compensate Summit for collection agency fees. I further authorize the release of my physical therapy records to insurance companies in order to process claims.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**PRIVACY PRACTICES**

This acknowledgement reflects the privacy standards set forth by the Department of Health and Human Services. A copy of Summit Physical Therapy's privacy practices is located at the front desk. You may also request a copy for yourself.

Signature \_\_\_\_\_ Date \_\_\_\_\_