PATIENT________________________ DATE OF BIRTH____________

REFERRING PHYSICIAN____________________

PRIMARY CARE PHYSICIAN ____________________

WOULD YOU LIKE A COPY OF YOUR EVALUATION TO YOUR PCP? Y / N

EMERGENCY CONTACT________________________ PHONE ____________

PAST MEDICAL HISTORY

Do you have, or have you had any of the following?

- ☐ Cardiovascular disease (CABG, sickle cell anemia, Heart valve problems, PACEMAKER, arrhythmia, heart attack)
  - ☐ Other____________
- ☐ Diabetes type I
- ☐ Diabetes type II
- ☐ Fibromyalgia
- ☐ Alzheimer's
- ☐ High Cholesterol
- ☐ High blood pressure
- ☐ Stroke
- ☐ Cancer:
- ☐ Lupus
- ☐ Osteoarthritis:
- ☐ Rheumatoid arthritis
- ☐ Epilepsy or seizure disorder
- ☐ Parkinson's Disease
- ☐ Lung disease (asthma, emphysema, COPD)
- ☐ AIDS and HIV positive
- ☐ OTHER________________________
- ☐ Previous Surgeries________________________

____

Physical Therapy History

- ☐ No
- ☐ Yes, explain:

Pregnant?

- ☐ No
- ☐ Yes

Adverse reactions to heat or cold?

☐ No Yes

FOOD OR DRUG ALLERGIES (PLEASE LIST)
☐ CHECK BOX IF NONE

CURRENT MEDICATIONS (LIST MEDICATIONS OR GIVE RECEPTIONIST A PREPARED LIST)		☐ CHECK BOX IF NONE
MEDICATION (prescription, vitamin, over the counter)	**STRENGTH** (example: 50mg)	**DIRECTIONS (2 pills in the morning)**

PLEASE LIST ANY FURTHER INFORMATION THAT WE SHOULD BE AWARE OF PRIOR TO TESTING AND/OR TREATNG YOUR CONDITION:

I AFFIRM THAT THE INFORMATION CONTAINED ON THIS FORM IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I ALSO ACKNOWLEDGE THAT I HAVE BEEN OFFERED A COPY OF BARSTOWN RD. PHYSICAL THERAPY GROUP, INC.'S NOTICE OF PRIVACY PRACTICES AND THAT I MAY REQUEST A COPY AT ANY TIME.

______________________________ Patient Signature

______________________________ Date

Consent Regarding Medical Insurance

Medical insurance plans continue to change and are expecting individuals to be financially responsible for more of their medical costs. Since we feel strongly that our patients deserve the best physical therapy care we can provide, and to maintain a high quality of care, we would like to share some facts about medical insurance with you. We consider our relationship with you to be of primary importance and will always make our recommendations to you based on what we believe is the very best treatment for you regardless of your insurance coverage. As a patient, it is your responsibility to deal with your insurance company and your employer. We will assist in any way possible to maximize your health insurance benefits; however, you are responsible for understanding your insurance policy.

- Medical Insurance is not meant to be a "Pay-all," it is only meant to aid.
- Many plans tell their insured that co-payments are a certain amount but when verified they may be more if your plan considers physical therapy as a "specialist." Some plans expect your percentage payment to be more, some expect less. The amount your plan pays is determined by the contribution you and your employer make to your medical plan. It is your responsibility to advise us of your insurance coverage restrictions.
- Each plan utilized in our office has different percentages, deductibles, maximums, procedures covered and varying fees that the plan will allow. We will do our very best to make as close a calculation as possible, however, we cannot estimate precisely.
- We have chosen not to participate in all the insurance plans available, but we will provide you with a **SUPER BILL** which you can submit to your insurance company for reimbursement directly to you for your care. You will be asked to pay for your services at the time of delivery.

Consent Regarding Physical Therapy Evaluation and Treatment

By signing this, I hereby consent to the rendering of a physical therapy evaluation and treatment as deemed appropriate by the treating therapist. I have the right to decline treatment at any time. Your therapist will explain your physical therapy diagnosis and discuss treatment recommendations with you. We strive to provide the highest quality care with minimal discomfort, however, some conditions require "pushing into pain" and we will do our best to make you as comfortable as possible afterwards using pain management modalities. Physical therapy, like any other type of medical care, is most effective if you participate according to the treatment plan agreed upon with your therapist. If at any time you have questions concerning the type of services delivered or how your services are rendered, please talk with your therapist. Remember, we are here to provide you with the best care available to improve your quality of life through physical therapy. If you agree, please check all (otherwise discuss with front office):

- ☐ I authorize the release of all necessary information to my primary care provide and/or referring physician.
- ☐ I authorize payment benefits directly to the provider.
- ☐ I authorize the release of my medical information to ____________________ in regard to my care and/or status.
- ☐ I have read this form and agree to be financially responsible for all fees regardless of insurance coverage.
- ☐ I have read this form and agree with all consent regarding physical therapy treatment and assessment.

Signature of Patient/ Legal Guardian____ Date__________

4233 Bardstown Road, Louisville, KY 40218 Phone: 502-493-3800 Fax: 502-493-3830

Date: ____________________

Name: ____ SSN: ____________________________

Address____

City: __________________________________ State: _____________ Zip: _______________________

Phone: (cell) ___________________ Email: ____

Date of Birth: _________________________Sex: M F Marital status: ____________________

Spouse name:__________________________Employer:______________________________________

Person Responsible for Account if different from above:

Name: _______________________________________ Relation: _________________________________

SSN: ____________________________ Address: ____

Medical Insurance Information:

Primary Insurance Company: ____

Secondary Insurance Company: ____

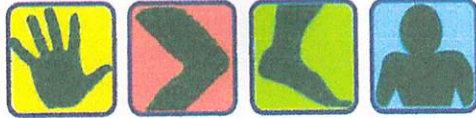
Policy Holder's Name: _______________________________________ Relation: _____________________

SSN: _____________________________ Date or Birth: _______________________

I understand that payment is my obligation regardless of insurance or any other third party involvement.

Signature: ____Date: _________________________

4233 Bardstown Road, Louisville, KY 40218 Phone: 502-493-3800 Fax: 502-493-3830



Patient Rights & Responsibilities

We welcome you and thank you for choosing Physical Therapy Group, Inc. to provide your care. You, have the right to receive professional care from all of our staff in a pleasing environment. Your therapist will discuss your treatment diagnosis and your plan of care in advance of any treatment. You have the right to have all of your questions that fall within the physical therapy scope of practice answered in a timely manner. Recommendations and referrals will be made for any condition outside of physical therapy. You have the right to one full copy of your physical therapy medical record without any monetary charge. You have the right to a copy of Physical Therapy Group, Inc.s privacy practices per request.

No Show, Late Arrivals and Cancellation Policy

We want you to gain maximal benefit from your physical therapy care. In order for this to occur, your full participation is needed. We understand that life is busy and sometimes unpredictable. In the case you cannot attend a scheduled appointment, call us and we will do our best to accommodate the change. We reserve the right to apply a $50.00 fee if the notice is not provided 24 hours prior to the scheduled appointment. If you are more than 10 minutes late for an appointment you may be asked to reschedule. We reserve the right to discontinue your care if you cancel or fail to show for (3) or more appointments during the scheduled plan of care.

Signature____ Date_______________

4233 Bardstown Road, Louisville, KY 40218 Phone: 502-493-3800 Fax: 502-493-3830