Wyomissing Physical Therapy

Date:_____

Patient Name:_____
Last

_____
First Middle Initial

Address:_____

City:_____ St:_____

Zip:_____

Email:_____

Phone:(_____)_____

Cell Phone:
(_____)_____

Sex Male☐ Female ☐

DOB:_____

Occupation:_____
Employer/
School:_____

Whom may we thank for referring you?

_____

IN CASE OF EMERGENCY, CONTACT

Name:_____

Relationship:_____

1st contact #:(_____)_____

Is this condition due to an accident Yes☐ No ☐

Allergies:_____
_____

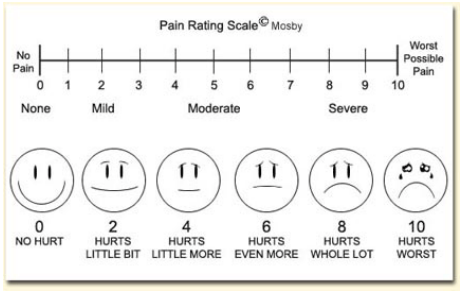
Primary Insurance _____

ID#_____

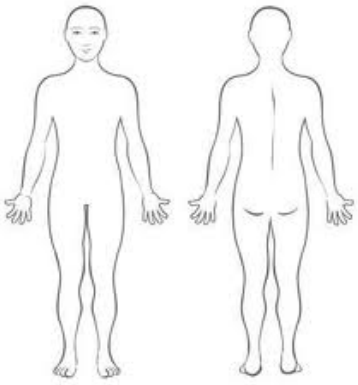
Secondary _____

ID#_____

Rate the severity of your pain:



Mark an X on the picture where you have pain, numbness, weakness or tingling.



Front Back

Primary
Doctor:_____

Medications (prescriptions and
OTC)_____
_____
_____
_____
_____
_____

Health History

__ Abdominal Pain
__ AIDS/HIV
__ Anxiety/Depression
__ Urinary Tract Infection
__ Vascular Disease
__ Cancer
__ Chemical Dependency
__ Low Blood Pressure
__ Low Blood Sugar
__ Scoliosis
__ Nausea/Vomiting
__ Fainting
__ Fever/Chills
__ Pneumonia
__ Headaches
___Tuberculous
__ Hernia
__ Asthma
__ Bleeding Disorder
__ Kidney Disease
__ Liver Disease
__ Prosthesis
__ Lyme Disease
__ Dizziness
__ Epilepsy/Seizures
__ Osteoporosis
__ Pacemaker/Defibrillator
__ GERD
__Stroke
__ Hepatitis
__ Ulcers
__ High Blood Pressure
__ High Cholesterol
__Gout
__ COPD
__ Circulatory Problems
__ Diabetes
__ Migraines
__ Numbness/Tingling
__Guillain-Barre Syndrome
__ Fibromyalgia

Other Medical Conditions_____

Pregnant: ❑ Yes ❑ No Due date:_ _____

I would rate my health as: ❑Excellent ❑Good ❑Fair ❑Poor

Have you had any falls in the last six months? If yes, approximately how many? _____

Orthopedic History:
_____

_____

_____

Surgeries_____

PATIENT NAME: _____

WYOMISSING PHYSICAL THERAPY FINANCIAL POLICY

We would like to THANK YOU for choosing WYOMISSING Physical Therapy. Wyomissing Physical Therapy accepts third party payments and will submit your bills for treatment to the address provided as a courtesy to you. In order for us to bill your insurance company on a regular basis, we request that you sign this release of information and assignment of benefits (if applicable). Typically, insurances pay a predetermined amount of our treatment charges; however it is your responsibility to call your insurance company to check on the coverage provided by your individual policy. As a courtesy to you, we will perform an insurance verification with your insurance company; however we will not take responsibility for any misinformation that we are given during this process. Therefore, it is within your best interest to verify your outpatient benefits with your individual insurance plan and to confirm them with our office prior to initiating treatment.

Please initial after each Acknowledgement

CONSENT FOR CARE AND TREATMENT: I hereby give written consent for the provision of treatment. I authorize Wyomissing Physical Therapy to furnish treatment which is considered necessary and proper in diagnosing or treating my physical condition. _____

FINANCIAL RESPONSIBILITY: I understand that in some instances the applicable insurance may not cover all treatment charges incurred. I agree to be financially responsible to Wyomissing Physical Therapy for any medically necessary therapeutic services that are deemed uncovered by my insurance policy. _____

ASSIGNMENT OF BENEFITS: I hereby authorize payment directly to Wyomissing Physical Therapy, any benefits payable to me and/or my qualified dependents under the insurance coverage or Major Medical provisions of insurance coverage identified on bills submitted by Wyomissing Physical Therapy for treatment._____

CO-PAYMENTS: I understand that if my insurance plan requires a co-payment for treatment, my co-payment will be collected at the time of my visit. A surcharge may be applied in order to collect late co-payments. This surcharge will cover expenses incurred by Wyomissing Physical Therapy to generate additional bills and/or utilize collection services. _____

LITIGATION ACCOUNTS: I understand that Wyomissing Physical Therapy will directly bill my appropriate insurance; however I am responsible for the payment of my treatment, not the entity being sued. Liability action against someone else will not enable me to refuse payment to Wyomissing Physical Therapy. _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES AND AUTHORIZATION: I hereby acknowledge that I have received a copy of Wyomissing Physical Therapy's Notice of Privacy Practices. I also understand that additional copies of the Notice are available for my review upon request. By way of my signature below, I provide Wyomissing Physical Therapy with my authorization and consent to use and disclose my protected health information for the purposes of treatment, payment and health care operations as described in the Notice of Privacy Practices. _____

CERTIFICATION OF IDENTITY: I certify that I am in fact the individual claim to be. I understand that the knowing and willful use of another individual's personal identifying information under false pretenses is a criminal offense. _____

Photo Release: I grant Wyomissing Physical Therapy, its representatives and employees the right to take photographs of me and my property in connection treatment, office function and social media purposes. Verbal permission will also be attained before any posting to social media accounts. _____

I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND ALL COMPONENTS OF WYOMISSING PHYSICAL THERAPY FINANCIAL, PRIVACY AND CANCELATION POLICIES AS STATED ABOVE.

Signature of patient or guardian_____ Date_____