PRIME CARE PHYSICAL THERAPY, P.C.
NEW PATIENT INFORMATION

Patient Name: _____ ( ) Male ( ) Female
Last First MI

Address: _____
Street City State Zip Code

Home Phone: ( ) _____ Cell Phone: ( ) _____ Email Add: _____

Do you want appointment reminder? ( ) **Yes** ( ) Home Phone ( ) Cellphone ( ) Text ( ) Call ( ) **No**

Birth Date: _____/____/_____ Age: _____ ( ) Single ( ) Married ( ) Minor ( ) Other

Patient's Employer: _____ Work Phone: ( ) _____

Employer Address: _____
Street City State Zip Code

Spouse or Parent/Guardian's Name: _____ Phone: ( ) _____

Person to contact in case of emergency: _____ Phone: ( ) _____

Whom may we thank for referring you? _____

INSURANCE INFORMATION

Primary Insurance: _____ ID #: _____

Name of Principal Card Holder: _____ Birth Date: ___/ ___ /_____
Last First MI

Relationship to patient ( ) Self ( ) Spouse ( ) Parent

Secondary Insurance: _____ ID #: _____

Name of Principal Card Holder: _____ Birth Date: ___/ ___ /____
Last First MI

Relationship to patient ( ) Self ( ) Spouse ( ) Parent

AUTHORIZATION AND RELEASE
I authorize release of any information concerning my (or my child's) healthcare, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

_____ _____/ _____ / _____
Signature of Patient (Parent/Guardian) Date

PRIME CARE PHYSICAL THERAPY
NEW PATIENT HEALTH QUESTIONNAIRE

Patient Name: _____ Date of Birth: ____/_____/_____

HISTORY OF PRESENT ILLNESS

Main complaint: _____

Quality/Severity of pain/symptom: _____

When did it start? _____

Associated symptoms: _____

Did you have any surgery for your condition? ( ) Yes - Date of surgery: ____/____/_____ ( ) No

MEDICAL HISTORY *Check if you ever had the following:*

( ) AIDS/HIV	( ) Cancer	( ) Heart Disease	( ) Pacemaker
( ) Arthritis	( ) Diabetes	( ) Hernia	( ) Tuberculosis
( ) Asthma	( ) Dizziness	( ) High/Low Blood Pressure	
( ) Back / Neck Pain	( ) Epilepsy	( ) Joint Replacement / Surgery	
( ) Blood Transfusion	( ) Fibromyalgia	( ) Migraine / Headache	

Medications (including non-prescription): _____
_____

SOCIAL HISTORY

Tobacco use ( ) Never ( ) Rarely ( ) Moderate ( ) Daily
Alcohol use ( ) Never ( ) Rarely ( ) Moderate ( ) Daily
Drug use ( ) Never ( ) Type/Frequency _____
Excessive exposure to ( ) Dust ( ) Fumes ( ) Solvents ( ) Airborne particles
( ) Noise ( ) Other chemicals _____

FAMILY MEDICAL HISTORY

	Known Diseases	If deceased, cause of death
Father	_____	_____
Mother	_____	_____
Sibling	_____	_____
Children	_____	_____

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information may be dangerous to my health. It is my responsibility to inform this office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ ____/ ____/ _____
Signature of Patient (Parent/Guardian) Date

AUTHORIZATION TO USE OR DISCLOSE
PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of request: ____/_____/_____

Address: _____
Street City State Zip Code

Date of birth: _____/_____/_____

As required by the Privacy regulations, this practice may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

I hereby authorize this office and any of its employees to use or disclose my patient health information to the following persons: *(you may write doctor's name and/or family member's name)*

_____

_____

_____

_____

Patient Health Information to be disclosed: *(check all that applies)*

( ) Physical therapy reports
( ) Medical tests
( ) Others: _____

Effective dates for this authorization: _____ / _____ / _____ to _____ / _____ / _____
(you may use date of initial visit as your start date and authorization can end up to one year from start date)

_____
Signature of Patient / Authorize Representative

ASSIGNMENT OF BENEFITS / RIGHT FOR DIRECT PAYMENT TO PROVIDER

I hereby instruct _____ insurance company to pay Prime Care Physical Therapy, P.C. for professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered.

This is a direct assignment of my rights and benefits under this policy.

I have agreed to pay my balance of said professional service charges over and above this insurance payment, including co-pay / co-insurance or deductible as approved by my insurance.

I also understand and agree that I am ultimately responsible for any professional fee due should my insurance refuse to pay my physical therapy provider.

I authorize release of any information pertinent to my case to any insurance company, health care financing administrator, adjustor or attorney involved in this case.

A photocopy of this assignment shall be considered as effective and valid as the original.

_____ ____ / ____ / _____

Signature of patient / Authorized representative Date

_____

Name of patient / Authorized representative

NO SHOW / NO CALL CANCELLATION POLICY

Please read & write your initial on the line provided.

_____ All patients are required to call 24 hours in advance to cancel or re-schedule an appointment. Our office reserves a one-on-one appointment with the therapist for you and that slot cannot be filled up with another patient if it is a last minute cancellation or no show.

_____ Patient will be responsible for a **$25** courtesy fee if you miss your appointment, do not call within 24 hours, or request a last-minute re-scheduling. We cannot bill your insurance for this fee or for any no show appointment.

We understand medical and personal emergencies can happen. We hope you value your therapist's time as much as we value yours. Thank you for your understanding and cooperation!