Patient Medical History

Patient Name: _____ Date of Birth: _____ Home Ph#: _____

Address: _____ SS#: _____ Work Ph#: _____

City: _____ Email: _____

State: _____ Zip: _____ Marital Status: ○ Single ○ Married ○ Widowed

Emergency Contact: _____ Ph#: _____ Relationship: _____

Insurance Information

Is this service for treatment of a work-related injury or illness? ○ Yes ○ No

Is this service for treatment of an injury resulting from an automobile accident? ○ Yes ○ No

Have you received any services from a Home Health Agency within the past 90 days? ○ Yes ○ No

Name of Home Health Agency: _____ Ph#: _____

Home Health Start Date: _____ Discharge Date: _____

Are you presently receiving services from a Home Health Agency? ○ Yes ○ No

****Please Note: Medicare will not pay for concurrent Home Health Services and Outpatient Therapy Services.****

Medical History

Please list any medications you are presently taking or provide your own list: _____

_____

Please indicate any recent X-Rays, CT Scans or other medical tests taken for this condition; when and where they were taken:

_____

Please check any of the following medical conditions you have been diagnosed with or have experienced:

○ Allergies	○ Diabetes	○ High Blood Pressure	○ Parkinson's Disease	○ Urinary Tract Infection
○ Arthritis	○ Dizziness	○ Irritable Bowel Syndrome	○ Pneumonia	○ Ulcers
○ Asthma	○ Emphysema	○ Kidney Problems	○ Polio	
○ Cancer	○ Heart Disease	○ Liver Disease	○ Ringing in Ears	Are you pregnant?
○ Chest Pain	○ Heart Attack	○ Osteoporosis	○ Shortness of Breath	○ Yes ○ No
○ Chronic Bronchitis	○ Hepatitis/Jaundice	○ Pacemaker	○ Stroke	

Please note any other past medical problems / illness / surgeries or hospitalizations within the last 30 days: _____

_____

Reason for Therapy: _____ Date of Onset: _____

Please note any previous therapy:

Clinic: _____

Dates: _____

Rate your pain on a 0 - 10 scale:

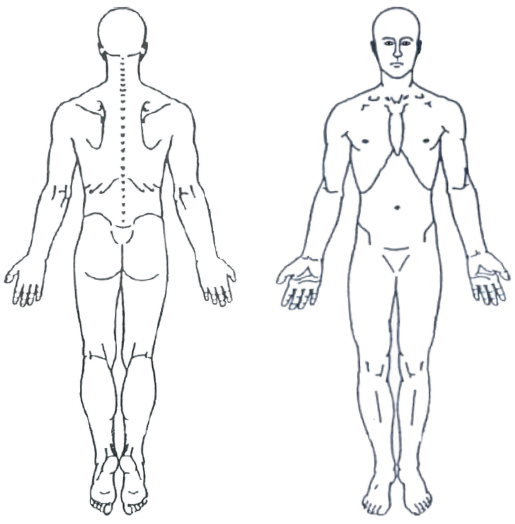
(0) = no pain: (10) = had to go to Emergency Room

Pain level today: _____

Worst pain in the past 30 days: _____ Date: _____

Least pain in the past 30 days: _____ Date: _____

Please indicate any problem areas, i.e. pain, swelling, weakness, etc.



I certify that the above information is true and complete to the best of my knowledge.

_____ _____

Signature *Date*

Consent for Treatment & Financial Agreement

Consent for Medical Services & Treatment

I consent to treatment, diagnostic and/or therapeutic services ordered and/or provided by Agility Physical Therapy's Physical and/or Occupational Therapists

Financial Agreement

The undersigned individually obligates him/herself and guarantees prompt payment of all charges for services rendered to the patient when not covered by insurance carriers or others. A minimum fee of $35 will be charged for each returned check. The maximum charge permitted by law is the greater of $40 or 5% of the face amount of the check. The check-writer is also responsible for all of the cost of collection. Payment of any unpaid balance is due within 30 days of final billing. If payment is not received within 30 days from the date of billing, finance charges may begin to accrue at the maximum rate allowable by law. In addition, such balance may be turned over for collection activity, at which time the undersigned shall be liable for attorney's fees and/or collection agency's fees and expenses. The undersigned understands that Agility Physical Therapy & Sports Performance has the right to examine credit bureau files for financial information regarding collection of unpaid debt.

Assignment of Benefits

In the event that I am entitled to benefits of any and all types, I assign such benefits to Agility Physical Therapy and Sports Performance for services rendered to me. I authorize payment directly to Agility Physical Therapy and Sports Performance of all such insurance benefits payable to me. Such insurance includes, but is not limited to, private commercial, auto/liability insurance, or any governmental program such as Medicare, Medicaid, or Worker's Compensation. I authorize Agility Physical Therapy & Sports Performance to release medical information to such insurance providers as necessary to satisfy conditions for payment of the assigned benefits. I certify that the information given regarding my insurance is accurate and correct.

Evaluation of Services and Follow-up

I understand that Agility Physical Therapy and Sports Performance and/or its agent(s) may contact me for the purpose of evaluating the services rendered to me

☐ Yes ☐ No

Medical Information Authorization

I authorize Agility Physical Therapy & Sports Performance to release all or part of my medical record information when required or permitted by law or government regulation, including any physican(s) or healthcare provider responsible for continuing care.

Name _____ DOB_____ Relationship_____

Name _____ DOB_____ Relationship_____

Name _____ DOB_____ Relationship_____

Name _____ DOB_____ Relationship_____

Name _____ DOB_____ Relationship_____

Please Initial here verifying the above information is true: _____

Medicare Recipient Notification

Currently Medicare has implemented a capitation for therapy services. Medicare recipients are limited to a total of $1960 towards Physical and Speech Therapy and an additional $1960 for Occupational Therapy during the calendar year.

To help Agility Physical Therapy and Sports Performance in obtaining the most accurate information as possible, it is my responsibility to inform Agility Physical Therapy and Sports Performance of any therapy services I have received within the calendar year. I will be fully responsible for any charges exceeding the capitation amount.

During this calendar year, have you received prior Physical, or Speech Therapy? ☐ ***Yes*** ☐ ***No***

If yes, approximate # of visits: _____

Please initial here verifying the above statement is true: _____

The undersigned certifies that he/she has read and understands the above, fully accepts all specified terms, therein, and can, at their request, **obtain a copy of the HIPPA Notice of Privacy Practices.**

Signature of Patient or Legally Authorized Representative | *Print Name* | *Date*

Signature of Guarantor of Payment
(state relationship if other than patient) | *Print Name* | *Date*

Updated 06/2016

Cancellation/No Show Policy

Agility Physical Therapy requires 24 hour notice for the cancellation of a scheduled appointment. There is a $30 charge for a no-show or cancellation without proper notice. This charge ***will not*** be covered by your insurance. We understand that extenuating circumstances may occur which is why we have implemented a "two-strike" policy. We will allow for two cancellations before charging a fee. For every cancellation or no-show beyond two, a $30 fee will be assessed. Maintaining regular treatment sessions is essential for positive outcomes. Repeated cancellations and/or no shows will hinder your care and may result in discharge from our facility.

Lateness Policy

It is equally important that you be on time for your scheduled appointment. You are welcome to call in advance to request an earlier or later time. We will be happy to honor your request if other appointment times are available, however; simply arriving late or early changes the course of treatment for you and others. We cannot guarantee that we will be able to treat you if you are more than 15 minutes late for an appointment. Similarly, while we encourage you to arrive slightly prior to your scheduled appointment time, you will, likely, be asked to wait until your scheduled time if you arrive more than 5 – 10 minutes early for your appointment.

We take these policies seriously because when a patient misses an appointment, three people are adversely affected:

1. You, the patient – for not receiving the treatment you need. Maintaining regular treatment sessions is essential for positive, optimal outcomes – if you regularly miss treatment sessions, it is less likely we can help you achieve your goals.
2. Your therapist – as now he or she has a gap in the schedule.
3. Another patient – who could have had utilized that appointment time.

Please understand your pain may fluctuate as your course of treatment progresses and before you complete therapy. Having pain or *not* having pain are NOT reasons to cancel or fail to show for your scheduled treatment. If you are in pain, it is important to come in because there are treatments available and/or program modifications that can help lessen your pain, and it is essential to continue treatment of the underlying cause of your pain. Likewise, if you are no longer experiencing pain, it is important to continue your course of treatment to correct the underlying causes of your injury in order to prevent future setbacks.

I consent to the above, as indicated by my signature below:

Print Name

Signature Date