Patient Medical History

Patient Name: _____ Date of Birth: _____

Address: _____ Home Ph: _____ Cell Ph: _____

City: _____ State: _____ Zip: _____ How did you hear about us? _____

Email: _____ Height: _____ Weight: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Insurance Information

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

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

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

Name of Home Health Agency: _____ Ph#: _____

Home Health Start Date: _____ Discharge Date: _____

Are you presently receiving services from a Home Health Agency? O Yes O 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:

O Allergies	O Diabetes	O High Blood Pressure	O Parkinson's Disease	O Urinary Tract Infection
O Arthritis	O Dizziness	O Irritable Bowel Syndrome	O Pneumonia	O Ulcers
O Asthma	O Emphysema	O Kidney Problems	O Polio	O Current Smoker? Y/N
O Cancer	O Heart Disease	O Liver Disease	O Ringing in Ears	O Pregnant? Y/N
O Chest Pain	O Heart Attack	O Osteoporosis	O Shortness of Breath	O Depression? Y/N
O Chronic Bronchitis	O Hepatitis/Jaundice	O Pacemaker	O 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:

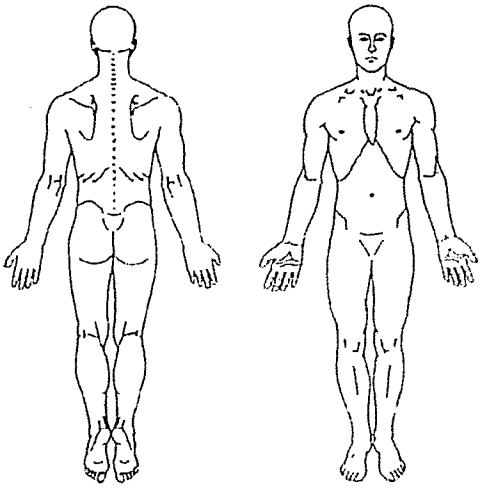
(0) = no pain: (10) = had to go to Emergency Room

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 as ordered and/or provided by Agility Physical Therapy's Physical Therapists.

Cancellation/No Show Policy

Agility Physical Therapy requires a 24-hour notice for the cancellation of a scheduled appointment. There is a $40 charge for a no-show or cancellation without proper notice. This charge will not be covered by your insurance. 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. We cannot guarantee that we will be able to treat you if you are more than 10 minutes late for an appointment. We encourage you to arrive a little early for your scheduled appointment time so your treatment can begin on time.

Important Information Regarding Your Treatment Plan

Please understand that pain can fluctuate as your course of treatment progresses. If you are in pain, it is important to let us know at your scheduled visits 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.

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 checkwriter is also responsible for the entire 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.

Assignment of Benefits

If I am entitled to medical benefits, I assign such benefits to Agility Physical Therapy & 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.

Release of Information

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 physicians or healthcare provider responsible for continuing care.

Medical Information Authorization

I authorize Agility Physical Therapy & Sports Performance to release any, and all medical information to family members and/or friends listed below:

Name _____ DOB_____Relationship_____

Name _____DOB_____ Relationship_____

I understand I have the right to request a copy of the Notice of Privacy Practices for Agility Physical Therapy prior to signing this form.

The undersigned certifies that he/she has read and understands the above, and fully accepts all specified terms, therein.

_____ _____

Signature of Patient, Guardian or Legal Representative Printed Name Date