## PATIENT INFORMATION

### Personal Profile

Name: _____ DOB: _____ Age: _____ Sex: _____

Address: _____

City: _____ State: _____ ZIP: _____

Primary Phone Number: _____ Secondary Phone Number:_____

Email: _____ SSN: _____

### Emergency Contact

Name: _____ Primary Phone Number: _____

Relation to Patient: _____

### Referring Physician

Name: _____ Date of Last Visit: _____

### Additional Information

How did you hear about us? _____

**We are required by applicable federal and state laws to maintain the privacy of your protected health information. We are also required to provide a notice about our privacy practices, our legal duties, and your rights concerning your protected health information. Copies of the privacy policy are available at the front of the office. Please sign below to indicate that a notice of our privacy policies has been made available to you.**

**Signature:** _____ **Date:** _____

**I hereby give my authorization and consent to receive physical therapy treatment from Watchung Hills Physical Therapy, LLC. I freely choose to enter into treatment and I understand that I may discontinue treatment at any time. I acknowledge that no guarantees have been made to me regarding the outcome of my care. I understand that there are inherent risks involved when performing physical therapy and exercise.**

**I understand that payment is due at time of service. I understand that I am responsible for any payments not covered by insurance. If my account must be sent to an outside collections agency, I understand that I am responsible for all associated fees plus a $200 administrative fee payable to Watchung Hills Physical Therapy, LLC.**

**I acknowledge that, if this injury is in any way related to a motor vehicle or workplace accident, I have informed the staff of this situation.**

**Signature:** _____ **Date:** _____

## MEDICAL HISTORY

Reason for visit: _____

_____

Please rate your pain severity on a scale from 0 to 10 (0 = no pain, 10 = worst possible pain):

At best: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 At worst: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Height: ____ ft. ____ in. Weight: _____ lbs. Occupation: _____

Recreational/exercise activities: _____

Please list any known allergies: _____

(For women) Are you currently pregnant or do you think you may be pregnant? Yes || No

Have you recently experienced any of the following (please check all that apply)?

| | | | |
|---|---|---|---|
| □ fatigue | □ falls | □ heartburn/indigestion | □ shortness of breath |
| □ fever/chills/sweats | □ numbness/tingling | □ difficulty swallowing | □ fainting |
| □ nausea/vomiting | □ muscle weakness | □ constipation | □ cough |
| □ weight loss/gain | □ dizziness/lightheaded | □ diarrhea | □ headaches |
| □ difficulty maintaining balance while walking | | □ changes in bowel or bladder function | |

Have you ever been diagnosed with any of the following conditions (please check all that apply)?

| | | | |
|---|---|---|---|
| □ cancer | □ anemia | □ rheumatoid arthritis | □ osteoporosis |
| □ heart problems | □ AIDS/HIV | □ bone or joint infection | □ multiple sclerosis |
| □ chest pain/angina | □ chemical dependency | □ kidney problems | □ epilepsy |
| □ high blood pressure | □ depression | □ urinary tract infection | □ eye problems |
| □ circulation problems | □ lung problems/asthma | □ bladder infection | □ ulcers |
| □ blood clots | □ tuberculosis | □ thyroid problems | □ liver problems |
| □ stroke | □ osteoarthritis | □ diabetes | □ hepatitis |
| □ pneumonia | □ pelvic inflammatory disease | | |

Please list any other known medical conditions: _____

Please list current medications, if any (include frequency and dosage): _____

_____

Please list recent surgeries, if any (include dates): _____

Have you fallen in the past year? Yes || No Do you worry about falling? Yes || No

Do you feel unsteady when standing or walking? Yes || No

Over the last 2 weeks, how often have you been bothered by any of the following problems?

(0 = Not at all 1 = Several days 2 = More than half the days 3 = Nearly every day)

Little interest or pleasure in doing things: _____ Feeling down, depressed, or hopeless: _____

## Medicare Patients Only

### Medicare Signature on File

I request that payment of authorized Medicare benefits be made on my behalf to Watchung Hills Physical Therapy, LLC for any services furnished to me by them. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

**Signature:** _____ **Date:** _____

### Supplemental/Secondary Insurance Signature on File

I request that payment of authorized Medicare Supplemental benefits be made on my behalf to Watchung Hills Physical Therapy, LLC for any services furnished to me by them. I authorize any holder of Medicare information about me to release any information needed to determine these benefits payable for related services.

**Signature:** _____ **Date:** _____

**All Medicare patients will have to satisfy their deductible and this is their responsibility. Watchung Hills Physical Therapy, LLC will submit your claims to Medicare. Medicare will cover 80% of allowable charges after your deductible is met.**

**Watchung Hills Physical Therapy, LLC. will not submit to your secondary insurance. Please make sure that you have the rollover program Medicare provides as this allows Medicare to submit to your secondary insurance. If you do not have the automatic rollover to your secondary you must call your secondary insurance carrier and advise them that you want to be enrolled into the automatic crossover program that Medicare provides. Our insurance company will contact Medicare's Coordination of Benefits Department and provide them with the necessary insurance information. This is a free benefit to all Medicare patients. If Medicare does not submit to your secondary and/or tertiary insurance you are responsible to do so after paying any unpaid balances to Watchung Hills Physical Therapy, LLC.**

**Patients will be responsible for all deductible, copays and coinsurances. Medicare sets a cap to outpatient physical therapy benefits each year and I agree to pay all balances if my cap has been met and further therapy was performed.**

**Signature:** _____ **Date:** _____