Step by Step Physical Therapy

In order to serve you most effectively, please provide us with the following information. All information is strictly confidential.

Patient Name: _____ **D.O.B**_____ **Marital Status**: M S W Other

Billing Address: _____

Phone (H): ( )_____ (**W**): ( )_____ (**C**): ( )_____

Email Address:_____ **Will you Accept texts**: **Y N**

Work Status: Employed Retired Student Disabled Other Currently working: Y / N Occupation: _____

Referring Physician:_____ **phone**:_____

Nature of Condition: Gradual / Injury / Employment / Motor Vehicle Accident / Unknown / Other Date of Onset:_____

Briefly Describe the problem you are here for:

_____

How did your problem occur:_____

What activities increase pain:_____

What reduces pain:_____

Most comfortable position:_____

On a Pain Scale (10 being the most severe), please circle your **CURRENT** pain level:

0 1 2 3 4 5 6 7 8 9 10

On a Pain Scale (10 being the most severe), please circle your **WORST** pain level in the **PAST WEEK**:

0 1 2 3 4 5 6 7 8 9 10

Current Medications: Please list or Attach list

_____

_____

Have you had any of the following: XRAYS CT SCANS MRI INJECTION OTHER**: Y / N** If yes, Where?_____

Have you been hospitalized or had surgery for <u>THIS</u> problem: **Y N** **If yes, Where**? _____

Date of surgery:_____ **Type of surgery**:_____ **# of times**:_____

Do you have any Hardware (screws, plates, metal implants)? _____

Do you have any Allergies: _____

Do you smoke or use tobacco: **Y N** If yes, How much? _____

Please circle any conditions that pertain to you: **Cancer: Current or Remission / Arthritis / Gout / Pregnancy / Diabetes / Epilepsy Stomach Problems / Bowel or Bladder Problems / Heart / Pacemaker / Osteoporosis / Unexpected weight :(circle) Loss / Gain / Other: _____**

Billing: **PLEASE MAKE SURE RECEPTIONIST GETS A COPY OF ALL CURRENT INSURANCE**

If you are not the subscriber, please provide subscriber info:

Primary:

Company Name:_____

Subscriber:_____ **DOB:**_____

Secondary:

Company Name_____

Subscriber:_____ **DOB:**_____

Workers Comp:

Company Name: _____

Address:_____

Adjuster:_____

Phone:_____ **Fax:**_____

Case#_____**SS#**_____-_____-_____

Employer:_____

Address:_____

Phone#:_____

Date Of Injury:_____

No- Fault:

Company:_____

Address:_____

Adjuster:_____

Phone:_____ **Fax:**_____

Claim#_____

Date of Accident: _____

Have you had any Physical Therapy in this current year? Y N If so, when_____

Have you recently or Currently receiving Home Care Services? Y N If yes, Discharge date: _____

Financial Responsibility: (Please Initial Acknowledgement _____)

You are responsible to provide us with the most up to date insurance card at the first appointment and upon any changes. All copays and co-insurances will be due each appointment. If you are working on a deductible, you will be responsible to pay $80 for the eval and $50 each follow up appointment. If the insurance charges more, we will let you know the difference and if the charge less, we will refund the difference.

Privacy Practice: (Please Initial Acknowledgement _____)

By law we are required to provide you with our Notice of Privacy Practices (NPP). This notice describes how your medical information may be used and disclosed by us. It also tells you how you may obtain access to this information.

Payment: (Please Initial Acknowledgement _____)

I hereby authorize payment directed to Step by Step Physical Therapy for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether paid by insurance, and for all services rendered on my behalf or my dependent. I authorize this office to release any information to secure payment of benefits. I authorize this signature on all insurance submissions.

I certify that all information I have provided is true and accurate.

Patient/ Guardian Signature: _____ **Date:**_____