Home Stretch Physical Therapy: Patient History Form

Name: _____Social Security #:_____

Address: _____ Apt#: _____

City: _____State: _____ Zip Code: _____

Billing Address (if different):_____

_____ Date of Birth: _____Sex: M or F

Phone: _____ **Email:**_____

Referring Physician: _____Location:_____

Type of Injury: _____Date of Injury_____

When is your next doctor's appointment scheduled? _____

Have you received physical, occupational, or speech therapy in the past year? (circle one) Yes No.

If yes, where and when ?_____

Have you or are you currently receiving care from a Home Care agency this year? (circle one)Yes No

If "yes" to above, which agency? _____

May messages be left on your home phone? (circle one) Yes No

How did you hear about Home Stretch Physical Therapy? _____

Insurance Information (please include all insurances)

Primary Insurance: _____ID # _____

Insurance Policy Holder: _____DOB:_____

Secondary Insurance: _____ID # _____

Insurance Policy Holder: _____DOB:_____

_____ X_____ _____

Patient's Name Printed Patient/Guardian Signature Date

Designated Individuals Authorization

I hereby authorize the designated party(s) below to request and receive any of my protected health information regarding treatment, payment or administrative operations. I understand that the identity of these designated parties will be verified before the release of any information.

Name: _____ Relationship/ph #:_____

Name: _____ Relationship/ph #:_____

Past Medical history

Do you now, or have you ever had any of the following conditions (check all that apply):

_____ Diabetes	_____ Heart Disease	_____ Dizziness
_____ High Blood Pressure	_____ Heart Attack	_____ Seizures
_____ Pacemaker	_____ Heart Murmur	_____ Cancer
_____ Kidney Problems	_____ Nervous Disorders	_____ Hernia
_____ Allergies to Heat	_____ Allergies to Ice	_____ HIV Positive
_____ Metal Implants	_____ Pregnant (currently)	_____ Epilepsy
_____ Breathing Difficulties	_____ Muscular Dystrophy	_____ Gout
_____ Rheumatoid Arthritis	_____ Multiple Sclerosis	_____ Fainting
_____ Hearing Loss	_____ Poor Eyesight	_____ Polio
_____ Migraine Headaches	Other: _____	

Please list any medications you are currently taking, including dosage (you may attach list):_____

Relevant Surgical History_____

_____ X_____ _____

Patient's Name Printed | Patient/Guardian Signature | Date

General Consent for Service, Release of Information & Financial Authorization

I. I voluntarily consent to the evaluation and treatment of my condition by a NYS licensed **Physical / Occupational** (circle applicable provider) Therapist . The therapist will explain the nature and purposes of these procedures, evaluation, and course of treatment. The therapist will inform me of expected benefits and complications, and any discomforts, and risk that may arise, as well as alternatives to the proposed treatment and the risk and consequences of no treatment.

II. I understand that as a courtesy to me, Home Stretch Phyiscal Therapy will bill my insurance carrier and make every reasonable effort to assist in expediting insurance payment. I, the patient, am responsible for all charges not paid by insurance. I understand that I am ultimately responsible in making sure my insurance company releases payment directly to Home Stretch Physical Therapy. Any payment sent to me will be forwarded to Home Stretch Physical Therapy. NOTICE OF ADVICE: treatment may not be covered by your specific health care plan or insurer without a referral. Co-insurances and Co-pays will be paid at time of visit or billed to patient or authorized designee.

III. I understand that Home Stretch Physical Therapy reserves the right to charge **$50.00 "cancellation fee"** of scheduled appointments with less than 24 hours notice. It will be MY sole responsibility to pay for these charges. Home Stretch Physical Therapy also reserves the right to discharge any patient, for any reason, including canceling of scheduled appointments. If my account has an outstanding balance over 30 days, it will be charged an additional $10.00 per month finance charge.

IV. I authorize the release of medical information necessary to process claims to insurance companies or their agencies (including Medicare) for the purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider.

V. I understand and agree that if it becomes necessary for Home Stretch Physical Therapy to commence any legal action or to obtain an attorney for collection of any outstanding balances on my account, I will be responsible for all reasonable fees incurred by Home Stretch Physical Therapy, in addition to the outstanding balance due.

VI. I agree to allow Home Stretch Physical Therapy to obtain any necessary medical history that will benefit my treatment outcome.

I have read the above certifications, or they have been read to me and I fully understand them.

_____ X_____ _____

Patient's Name Printed Patient/Guardian Signature Date

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