WESTCOTT
PHYSICAL THERAPY

PATIENT INFORMATION

Patient Name _____ **DOB** _____

Home # _____ **Cell #** _____ **Email** _____

Address _____

City/State/Zip_____

Emergency Contact _____ **Ph #** _____

Referring Physician _____ **Ph #** _____

Injury/Problem _____ **Date of injury/symptoms** _____

PRIMARY INSURED INFORMATION

Health Insurance Carrier _____

If Medicare, has patient seen a PT this year? _____ **Where?** _____ **# of visits** _____

Primary Insured Name _____ **Primary DOB** _____

Primary Phone # _____ **Relation to primary** Select from drop-down list

Primary Billing Address _____ **City/State** _____ **Zip** _____

Patient Information Consent Form

The HIPAA Privacy Notice describes how the Practice may use and disclose my health information for the purposes of obtaining payment, carrying out treatment, evaluating the quality of services provided, and any administrative operations related thereto. I understand that the Practice is required to maintain the privacy of my health information in accordance with the terms of this Notice. By signing this form, I consent to the Practice's use and disclosure of my health information as described in the Notice. I understand I have the right to revoke this consent at anytime in writing. I understand that WESTCOTT Physical Therapy will consider requests for restriction on a case by case basis, but needn't agree to these requests.

_____ _____

Signature of Patient/Legal Guardian **Date**

Payment/Policies/Medical Information Release Form

We welcome you to **WESTCOTT Physical Therapy**, and look forward to providing you with excellent treatment and service. As a courtesy, in most cases we will contact your insurance provider to verify eligibility and benefit information, which we will provide to you. **This verification is not a guarantee of benefit or payment. You should also contact your insurance company to request your physical therapy eligibility and benefits.** It is your responsibility to understand your insurance policy, which is a contract between you and your insurance provider.

Insurance and Payments: We will submit bills to most insurance companies on your behalf, and will assist you to maximize your insurance benefits. However, you are responsible for payment of all charges, including deductibles, co-insurance, co-payments and any and all denied charges. We will bill you periodically as we receive payments from your insurance company. If your insurance carrier does not remit payment to us within 60 days, the balance owed will be due in full by you. Insurance **co-payments** are due at the time of service. **For those without insurance**, payment in full is expected at the time of service.

Legal Costs: If it is necessary to commence legal action for the collection of any outstanding charges on your account, you will be responsible for our incurred costs and/or court fees, in addition to your outstanding balance.

Referrals: A written prescription for physical therapy may be necessary to bill your insurance. If a primary care physician's referral or a written prescription are required by the health insurance company, it is the patient's responsibility to provide us with this referral and any subsequent referrals needed for further treatment.

Cancellation/Sick Policy: We require 24 hours advance notice of cancellation; otherwise a $75.00 fee will apply. Please be on time for your appointments so that you may be given the full benefit of your scheduled treatment. Late arrival of more than 15 minutes may result in shortened treatment time or cancellation. If a patient is sick, please contact us as soon as possible to cancel your appointment. A patient must be fever-free and diarrhea-free for 24 hours prior to their scheduled appointment. You will not be charged for a canceled visit due to sickness.

Medical Records: Your provider uses a technology called Tapt Health to support their clinical documentation. This technology automatically transcribes and summarizes your visit, allowing your provider to better focus on your care. This documentation assistant is HIPAA compliant. By signing below, you consent to the use of Tapt Health during your treatment sessions. Further details about how Tapt Health will be used by your provider can be provided to you upon request.

Financial Agreement/Assignment of Benefits: By signing below, I authorize payment of medical benefits as determined by the Insurance Company directly to **WESTCOTT Physical Therapy**. I authorize the release of any medical information relating to all claims for benefits submitted on behalf of me and/or dependents. As a patient or legal guardian, I understand I am responsible to pay for all services rendered in accordance with the terms and conditions set forth in this policy. Any money paid to me by my insurance company for services rendered and billed by **WESTCOTT Physical Therapy** shall be paid to **WESTCOTT Physical Therapy** immediately upon receipt.

My signature on this form indicates that I have read, understand, and agree to the payment/policies/medical information release of **WESTCOTT Physical Therapy**.

_____

Patient's PRINTED Name

_____ _____

Patient Signature (Legal Guardian if under 18 years old) **Date**

Patient Name:_____ Date of Birth:_____ Date:_____

Current Physical Information

Occupation/Recreational Activities:

What brings you into physical therapy?

When and how did this problem begin?

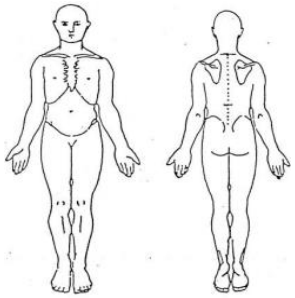
How would you rate your pain? Please mark the location(s) of any symptoms and/or pain

At best – Select one

At worst – Select one

0 -> no pain

10-> worst pain imaginable



Check the box if you are having symptoms or difficulty:

Walking ☐ Prolonged standing ☐ Prolonged sitting ☐ Balance ☐ Bathing ☐

Bending ☐ Dressing ☐ Driving ☐ Exercise ☐ Housework ☐ Lifting ☐

Turning ☐ Work Duties ☐ Memory ☐ Other _____

What helps DECREASE your symptoms?

Check the box for any equipment you are currently using:

Bath/Shower chair ☐ Brace ☐ Cane ☐ Commode chair ☐ Raised toilet seat ☐ Walker ☐

Do you have steps inside or outside the home? If yes, how many? _____ **Railing?** _____

Have you had any previous therapy or other treatment for this problem? _____

If yes, what type of treatment did you receive? _____ **Did it help?** _____

Patient Name:_____ Date of Birth:_____ Date:_____

Health History

Check the box for any past or present health problems that apply:

Diabetes ☐ Osteoporosis ☐ Cancer ☐ Pacemaker ☐ Heart Problems ☐

Prednisone Treatment ☐ High blood pressure ☐ High Cholesterol ☐

Other_____

Please list any surgeries, procedures, or injuries:

Circle any symptoms that apply

Bladder changes ☐ Fever/Chills ☐ Bowel Changes ☐ Nausea/Vomiting ☐

Difficulty breathing ☐ Night pain ☐ Dizziness/lightheadedness ☐ Numbness ☐

Changes in vision ☐ Sexual dysfunction ☐ Fainting ☐ Sadness/Hopelessness ☐

Thoughts of harming yourself or others ☐ Recent infections ☐ Tingling ☐

Unexplained weight loss/gain of 10 lbs ☐ Hearing changes ☐ Changes in cognition or memory ☐

Have you fallen within the last 6 months? _____ - **If yes, how many times?** _____

Were you injured?_____

Do you have allergies or adverse reactions (adhesive tape, latex, steroids, cleaning solutions)?

What diagnostic test have you had relating to this current problem? Please list the year.

X-Ray _____ MRI _____

Bone density _____ Other _____

Medications

Are you taking any medication? If yes, please list all the medications you are currently taking.

Medication	Dose	Directions for Use

Goals

What are your goals for physical therapy? _____