Humphries Physical Therapy

Patient Demographic Form

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

Social Security #: _____-_____-_____ Marital Status: _____ Gender: _____

If Patient is a Minor need Parent's Information. Full Name: _____

Social Security #: _____-_____-_____ Date of Birth: _____/_____/_____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: (H) _____-_____-_____ (C) _____-_____-_____ (W) _____-_____-_____

Email Address: _____

Emergency Contact: _____ Phone Number ____-____-_____

Insurance

Policy Holder's Full Name: _____ Date of Birth: ___/___/____

Policy Holder's Place of Employment: _____

Is your visit related to an accident? Yes/No If yes, what type? Aute ▫ School ▫ Work ▫

Other _____

If this is school related, please provide School Insurance information to the front desk.

Workers' Compensation

Employer: _____ Phone Number: _____-_____-_____

Employer's Address: _____

Accident Date: _____/_____/_____ Accident State: _____

Case Manager: _____ Phone Number: _____-_____-_____

Have you had Home Health? Yes/No **Date of Discharge: _____/_____/_____**

Patient/Guardian Signature: _____

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Medical History Questionnaire

1) What are your current symptoms? _____

_____

2) When and how did this begin? _____
3) Have you been previously treated for this condition? _____

_____

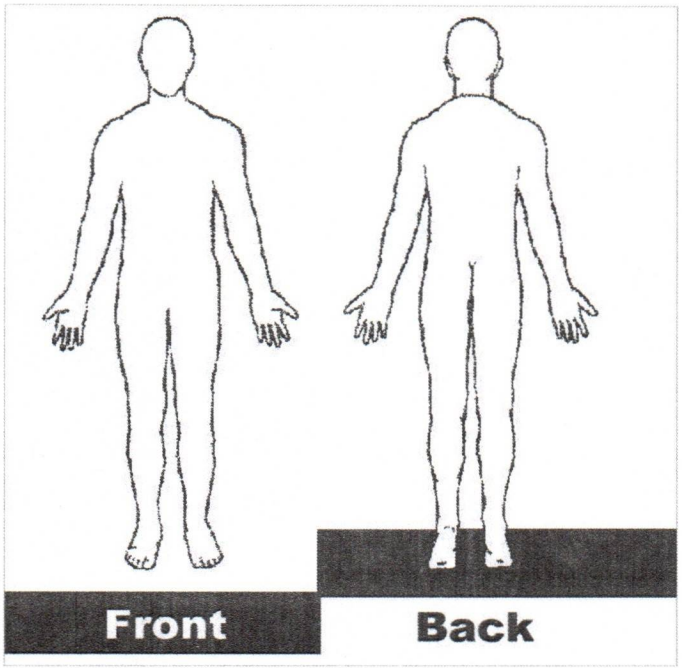
4) Have you missed work due to this condition? Yes/No Time missed? _____
5) Which activities are most limited by your current conditions? _____

_____

6) Which position, activities, or medications help with your symptoms? _____

_____

7) Please shade the area of where you are having your current symptoms:



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Medical History Questionnaire

8) Please check if you have/had any of the following

_ Heart Disease	_ Diabetes	_ Kidney Disease
_ Pacemaker	_Dizziness	_ High Blood Pressure
_ Vertigo	_ Hernia	_ Lower Leg Swelling
_ History of Falls	_ Acid Reflux	_ Fatigue
_ HIgh Cholesterol	_ Hearing Impairment	_ Anemia
_ Cancer	_ Osteoporosis	_ Headaches
_ Stroke	_ COPD	_ Depression/Anxiety
_ Chest pain	_ Thyroid	_ Seizures
_ Neurological Disease	_ Shortness of Breath	

Other: _____

9) What are your personal goals for therapy? _____

_____

_____

10) Please list any history of surgeries you've had and dates. _____

_____

_____

Patient/Guardian Signature: _____

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Patient Consent Form

Missed appointments

There is a $25.00 fee for NO CALL NO SHOWS.

Financial Policy

You are responsible for any amounts that are not paid, covered, or denied by your insurance carrier. Any balance not paid by your insurance carrier shall be due in full within 30 days from the date your insurance carrier pays its portion. You will then have 30 days to pay the remaining balance due. If after 30 days you have not paid the full amount due from you, your account will be sent to collection. We reserve the right to refuse treatment to any patient not paying their co-pay at time of visit or with outstanding balance.

Workers Compensation, Accidental Injuries, and Liabilities

If you are claiming Workers Compensation or filing claims through a liability carrier, you must provide us with a copy of your primary insurance card and a Physician's referral. Workers Compensation cases, we must have prior authorization from your Workers Compensation to begin treatment. In the event payment for your claims is denied by Workers Compensation or a liability carrier, we will file claims with your personal health insurance. If your claim is denied by your personal health insurance, you will be responsible for paying any balance due to Humphries Physical Therapy. In case of personal injury, you instruct and authorize your Attorney to pay directly to Humphries Physical Therapy. You agree that, in the event the liability carrier does not take care of balance, you will personally be responsible for the balance and/or cost for all services rendered.

Minor Patients

A Parent or Legal Guardian must accompany minor(s) at time of their Initial Evaluation. If Parents are separated and both legally responsible for treatment of their minor child, please provide complete information from both parents so we may bill the appropriate insurance. For unaccompanied minors that are required to pay a co-pay at follow up appointments, a pre-authorized credit card may be used, cash, or check at the time of service will be required.

Treatment

You hereby consent to the rendering of a physical therapy evaluation and treatment as deemed appropriate by the treating therapist. Your therapist will explain to you therapy diagnosis and discuss treatment recommendations with you. You have the right to decline treatment at any time. You have the right to decline treatment at any time. We strive to provide the highest quality of care. Therapy is most effective if you participate according to the plan of treatment agreed upon.

Medical Records Release

You authorize Humphries Physical Therapy to release any information pertinent to your case to any doctor, insurance company, case adjuster, or attorney involved in your case.

Privacy Practices

You have been offered the opportunity to review and to receive a copy of Humphries Physical Therapy's Notice of Privacy Practices September 2017. You recognize that for the purposes of treatment, payment, healthcare operations, as permitted or required by law, you give your written authorization to Humphries Physical Therapy to release any of your protected healthcare information.

By signing, I acknowledge that I have reviewed and agree to all the statements in this consent form.

Patient/Guardian Signature: _____

Humphries Physical therapy

51 Commerce St

Cadiz KY 42211

Photo Release Form

I hereby grant permission to (Humphries Physical Therapy) to post photographs and/or videos of myself on social media.

☐ Yes or ☐ No

_____

(Signature of Adult, or Guardian of Children under the age of 18)