



Patient Information

First & Last Name _____ **Today's Date:** _____
Date of Birth: _____ **Height:** _____ Male **Social Security#:** _____
Age: _____ **Weight:** _____ Female _____
Address: _____ **City, State, Zip:** _____
Cell Phone: _____ Text Appointment Reminder
Home Phone: _____ Automated Phone Call Reminder
Email: _____ Email is strictly used for communication from CORE regarding your plan of care & related physical therapy information. It remains confidential to CORE.
Occupation: _____ **How did you hear about CORE?** _____

Insurance Information

1) Primary _____ Policy ID # _____ Group _____
Medicare patients ONLY- Please make sure we have a copy of your RED, WHITE, & BLUE Medicare card. Policy Holder Name: _____ DOB _____
 2) Secondary _____ Policy ID # _____ Group _____
 Policy Holder Name: _____ DOB _____

Referring Physician

Doctor's Name: _____ **Is appointment due to:** Surgery Accident Other

Emergency Contact

Name: _____ **Phone #:** _____ **Relationship:** _____

Responsible Party

Self (skip to next section)
 Other - Name: _____ DOB _____ Social Security # _____
 Address: _____ City, State, Zip: _____

A. Have you had any previous treatment for your current condition?

Chiropractic Physical Therapy Injections Other: _____

B. Have you had any of the following diagnostic tests for your current condition?

MRI X-ray CT Scan Bone Scan EMG Other: _____

AUTHORIZATION FOR CARE/ INFORMED CONSENT

I/we hereby authorize to receive care at Core Physical Therapy & Rehabilitation. **I/we understand that receiving physical therapy may involve stress of musculoskeletal tissue that may cause soreness.** Additional risks include, but are not limited to cardiovascular, muscle, ligament, joint, or disc injury. Symptomatic aggravation of your current condition is possible.

Furthermore, I/we understand that the provider may need to perform mobilization technique, manipulation technique, massage technique, manual traction, distraction, and other movement modalities and services that may produce brief (several days) soreness and discomfort. **It is my/our responsibility to communicate any difficulties that I/we are having during treatment or any medical or activity changes to my/our provider.**

ASSIGNMENT & RELEASE (For All Patients)

I, the undersigned, assign directly to Core Physical Therapy & Rehabilitation, LLC all medical benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by my insurance.** I hereby authorize the physical therapist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic. **I also understand that if I have a co-pay it will be due at the time of service.** Medicare Authorization: I request that payment of authorized Medicare or Medigap benefits be made on my behalf to Core Physical Therapy & Rehabilitation, LLC for any services furnished to me by a physical therapist. I authorize any holder of medical information about me to release to the CMS and its agents any information needed to determine these benefits or the benefits payable for related services. If a secondary insurance is listed or provided, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

PAYMENT POLICY

Core Physical Therapy will bill your insurance company directly if you have provided us with all the necessary information to do so. The physical therapy services that you receive and the bill, is an agreement between you and Core Physical Therapy. Core Physical Therapy will require a copy of your credit card to run all open balances and/or a copy of your Care Credit Card. **It is ultimately your responsibility to see that your physical therapy bill is paid in full.** Agreements with insurance companies vary greatly and it is your responsibility to know what their portion is and what is yours. Any remaining money unpaid by your insurance company will be your responsibility to pay in a timely manner. Your balance statement you will receive will reflect what your insurance company, upon verification, told us is your portion to pay. We expect this payment within 30 days. **If payment is not received within this 30-day period, a 1.5 % finance charge may be assessed per month of balances not paid. In the event a check is returned for any reason, a \$35.00 charge will be made to your account. You agree to pay all costs and expenses. Amounts turned over to collections will be subject to a minimum 30% collection fee.** You are responsible for payment regardless of any insurance company's arbitrary determination of medical necessity. PT Plus Services are not covered by insurance and must be paid in full at the time of service. The parents (or guardians) accompanying a minor are responsible for payment of the minor's treatment.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose your protected information. I acknowledge that I have been offered the Core Physical therapy & Rehabilitation, LLC notice of Privacy Practices.

By signing below, I acknowledge that I have read and agree with the Core Physical Therapy's Authorization of Care/ Informed Consent, Assignment and Release, Medicare Authorization (if applicable), Payment Policy, and Acknowledgement of Privacy Practices

Signature: **X** _____ Today's Date: _____

Past Medical History

Do you have or have you ever been diagnosed with any of the following? Please circle Y or N below

Arthritis	Y / N	Epilepsy/ Seizures	Y / N	Pacemaker	Y / N
Bladder Problems	Y / N	Gout	Y / N	Psychological Problems	Y / N
Blood Clot/ Emboli	Y / N	Headaches	Y / N	Respiratory Problems	Y / N
Bowel Problems	Y / N	Hearing Problems	Y / N	Sleeping Problems	Y / N
Cancer	Y / N	Heart Condition	Y / N	Stroke/ TIA	Y / N
Chest Pain	Y / N	Hepatitis	Y / N	Thyroid Trouble	Y / N
Currently Pregnant	Y / N	High Blood Pressure	Y / N	Tuberculosis	Y / N
Do you smoke?	Y / N	HIV/ AIDS	Y / N	Vision Problems	Y / N
Diabetes	Y / N	Numbness/ Tingling	Y / N	Weight Loss/ Gain	Y / N
Dizziness/ Fainting	Y / N	Osteoporosis	Y / N	Other:	Y / N
Energy Loss	Y / N	Do you have an advanced directive?			Y / N

Please list any allergies: _____

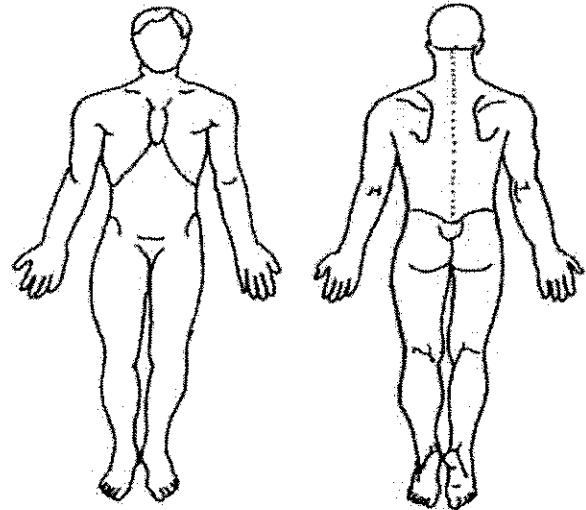
Currently, would you describe your overall health as: (circle one) Excellent, Good, Average, Below Average, Poor	
At the present time, whom do you live with? (Circle all that apply)	Alone, Spouse/Significant Other, Child(ren), Relatives, Group Setting, Parents
Do you have a safe home environment? (circle one) Yes / No If no, please discuss this with your therapist.	

Past Orthopedic Medical History

Please mark your areas of pain on the diagram below.

Please Indicate any previous orthopedic injuries or surgeries.

Neck Injury/ Surgery	Y / N
Shoulder Injury/ Surgery	Y / N
Elbow Injury/ Surgery	Y / N
Hand Injury/ Surgery	Y / N
Back Injury/ Surgery	Y / N
Hip Injury/ Surgery	Y / N
Knee Injury/ Surgery	Y / N
Ankle/ Foot Injury/ Surgery	Y / N
Have you had any falls in the past year?	Y / N





Medication Profile				
Name of Medication:	Dosage Amount:	Frequency:	By Mouth?	By Injection?

* Please note: Even if you are not taking any medications, please write 'None' on the Medication Profile and sign your name below.

Patient Signature: _____ Date: _____



CANCELLATION POLICY

Here at CORE we pride ourselves on our individualized care and flexible schedule. This flexible schedule depends on having open slots to add/move appointments on short notice. We understand that things come up, and you may not be able to attend your scheduled appointment. All we ask is that you call and cancel/reschedule at least 24 hours in advance. This opens up your appointment time for someone else to be seen and aids us in keeping our schedule flexible for our patients. If you fail to cancel your appointment in advance and/or miss your appointment our **Cancellation Fee of \$50.00** will be automatically charged to your account. Please sign below to indicate that you have read and agree with this policy.

Signature: _____ Date: _____