FIRST SETTLEMENT PHYSICAL THERAPY

PATIENT INFORMATION

Have you had therapy in the last 12 months? _____ If yes, where? _____

NAME: _____ DOB: ____/____/____
LAST FIRST M.I.

ADDRESS: _____
STREET CITY STATE ZIP

SEX: ☐ M ☐ F SSN: _____ PHONE: ( ) _____

MARITAL STATUS: ☐ M ☐ S ☐ W ☐ D EMPLOYER: _____

E-MAIL

(Refer to 'Email Consent' section on p.4 for email use/policy. If you leave this blank, we will assume that this means that you don't want to provide your email address for the uses listed in the Email Consent section on p. 4 or you don't have an email to provide.)

E-MAIL: _____

EMERGENCY CONTACT INFORMATION

In the event of an accident or a medical emergency, please list someone we may contact on your behalf:

NAME: _____ PHONE: _____ RELATIONSHIP TO PATIENT: _____

E-MAIL: _____

Would you like to list another person that may have access to your account information if you are unavailable? ☐ YES ☐ NO

If YES, NAME: _____ PHONE: _____ RELATIONSHIP TO PATIENT: _____

E-MAIL: _____

INSURANCE INFORMATION

PRIMARY: _____

SUBSCRIBER NAME: _____
LAST FIRST M.I.

SELF: ☐

SUBSCRIBER ADDRESS: _____
(if different than self) *STREET CITY STATE ZIP*

SEX: ☐ M ☐ F DOB: ____/____/____ SSN: _____ PHONE: ( ) _____

EMPLOYER: _____ RELATIONSHIP TO PATIENT: _____

SECONDARY: _____

SUBSCRIBER NAME: _____
LAST FIRST M.I.

SELF: ☐

SUBSCRIBER ADDRESS: _____
(if different than self) *STREET CITY STATE ZIP*

SEX: ☐ M ☐ F DOB: ____/____/____ SSN: _____ PHONE: ( ) _____

EMPLOYER: _____ RELATIONSHIP TO PATIENT: _____

FIRST SETTLEMENT PHYSICAL THERAPY

HOME HEALTH

Have you received any Home Health services in the past 30-60 days? ☐ YES ☐ NO

If you mark YES, please notify the front desk immediately.

Medicare will not cover physical therapy visits if you are receiving any home health services.

ACCIDENT INFORMATION (IF APPLICABLE)

Was injury due to a motor vehicle accident? ☐ YES ☐ NO

Do you have legal counsel for this accident? ☐ YES ☐ NO

Was this injury work related? ☐ YES ☐ NO

WORKERS' COMPENSATION CLAIM INFORMATION (IF APPLICABLE)

Date of Injury: _____ Claim Number: _____

In what state is your Workers' Compensation claim filed? ☐ Ohio ☐ West Virginia ☐ Other: _____

Contact/MCO Name & Company: _____

Employer: _____ Phone: _____

MEDICAL HISTORY

Please answer the following questions regarding your medical history.

Have you fallen more than two times in the last year? ☐ YES ☐ NO

- If YES, Have you discussed this, or Vitamin-D supplementation, with your doctor? ☐ YES ☐ NO

Do you currently use tobacco products? ☐ YES ☐ NO

- If YES, Have you or are you seeking counseling or medical treatment to help aid in quitting? ☐ YES ☐ NO

Have you ever been diagnosed with depression? ☐ YES ☐ NO

- If YES, Has it been treated? ☐ YES ☐ NO

Are you currently/have you been diagnosed with diabetes? ☐ YES ☐ NO

- If YES, Type I or Type II Diabetes? ☐ TYPE I ☐ TYPE II

Do you have neuropathy? ☐ YES ☐ NO

- If YES, Have you had your feet screened recently? ☐ YES ☐ NO

FIRST SETTLEMENT PHYSICAL THERAPY

MAIN PROBLEM OR COMPLAINT THAT BRINGS YOU HERE TODAY

Problem/Complaint: _____

Pain Level (Circle a Number): **0** **1** **2** **3** **4** **5** **6** **7** **8** **9** **10**

No Pain Severe Pain

PLEASE LIST ANY RECENT SURGERIES

1) _____ Date: ____/____/____ 3) _____ Date: ____/____/____

2) _____ Date: ____/____/____ 4) _____ Date: ____/____/____

DIAGNOSTIC TESTS FOR CURRENT PROBLEM/COMPLAINT

☐ XRAY ☐ MRI ☐ BONE SCAN ☐ EMG ☐ OTHER: _____

Height: ____ feet ____ inches Weight: ____ pounds Date of Injury: ____/____/____

MEDICAL HISTORY - CHECK ALL THAT APPLY

☐ Arthritis	☐ Difficulty lying flat	☐ Loss of appetite	☐ Rash
☐ Asthma	☐ Ear pain	☐ Low blood sugar	☐ Recent weight loss/gain
☐ Cancer	☐ Heart palpitations, Murmur	☐ Lung problems	☐ Shortness of breath
☐ Change in vision	☐ Heart problems	☐ Metals	☐ Stents
☐ Chest pain	☐ High blood pressure	☐ Nausea	☐ Thyroid issues
☐ Cough	☐ Hot or cold intolerance	☐ Pacemaker	☐ Tumors
☐ Diabetes	☐ Implants	☐ Paralysis	☐ Ulcers
☐ Dialysis	☐ Incontinence	☐ Psychiatric care	☐ Other: _____

PLEASE LIST ANY MEDICATIONS

_____

_____

_____

PLEASE LIST ANY ALLERGIES

_____

_____

_____

GOALS FOR PHYSICAL THERAPY

_____

_____

How did you hear about us?

☐ Doctor ☐ Family ☐ Friend ☐ Former Patient ☐ I'm a Former Patient

☐ Social Media ☐ TV Ad ☐ Billboard ☐ Google ☐ Other: _____

FIRST SETTLEMENT PHYSICAL THERAPY

We verify financial responsibility with your insurance provider. However, please be aware that we are occasionally given incorrect information. The following information is provided as a courtesy to you, but does not constitute a binding payment agreement. It is important for you to verify your responsibility with your insurance provider. If this information is missing, please check with the front office staff.

Co-Pay per visit: _____ **Co-insurance:** _____ **Deductible owed:** _____

Additional Information: _____ **Office Mgr:** _____

AUTHORIZATION AGREEMENT
Assignment of Insurance Payment, Email Consent & Use Policy, and Release of Medical Information/Consent to Treat

I hereby request that payment of authorized Medicare and Other insurance benefits be paid DIRECTLY to First Settlement Physical Therapy, Inc., for any services furnished to me by this practice. I further authorize the release to/from First Settlement Physical Therapy, Inc. any information required in the course of my examination and/or treatment. I understand that I am financially responsible for all the charges and services rendered, regardless of litigation, insurance reimbursement, co-pays, collection fees or pending claims. I understand that as the parent/guardian of a minor, I will be responsible for payment. I hereby consent to treatment by First Settlement Physical Therapy, Inc. (a copy of this authorization shall serve as effective as the original). *While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.*

Insurance Cards - You must present a current insurance card at the first visit. Patients with Medicaid must present a current card every month. If you do not present your insurance card at your first visit, you will be considered a self-pay patient until we receive your insurance card and verify your benefits.

Co-Pays/Standard Office Payment - Co-pay/co-insurance is due at the date of service. If you are unable to pay this amount, please speak with the front office manager.

Motor Vehicle Accident Policy - If your injury is the result of a motor vehicle accident, please inform the office manager at the initial date of service. Arrangements must be made with the billing office in regards to your account.

Work-Related Injuries - We will attempt to verify your Workers' Compensation claim with the information provided to us, however, a claim number is not a guarantee of payment. *If your claim or authorization for service is denied, for any reason, you are responsible for payment of the account balance.*

We Accept the Following Forms of Payment:
Cash • Check • Visa/MasterCard/American Express/Discover • Money Order • Care Credit

First Settlement Physical Therapy, Inc. will never share your email address to a third party. However, we will use it to send you login information to your Patient Portal. We may also use your email address to send you Home Exercise Programs (HEPs) that have been discussed between you and your therapist, contact you with reminders about your upcoming therapy appointments, or notify you about products and/or services we offer. We may also check on your progress after you have been discharged and/or ask for your feedback regarding your experience at First Settlement Physical Therapy.

Please understand that unencrypted email is not a secure form of communication and there is some risk that individually identifiable health information and/or other sensitive or confidential information that may be contained in such an email may be misdirected, disclosed to, or intercepted by unauthorized third parties. First Settlement Physical Therapy, Inc. will use the minimum necessary amount of protected health information in any electronic communication with you. By signing below, you consent to receiving emails as discussed above, consent to accept the potential risks involved in receiving personal health information via email, and understand that you may withdraw your consent at any time by speaking with the front office staff.

I, the undersigned, hereby certify that I have read, understood, and agree to the above financial policy, email consent & use policy, and have received a Notice of Privacy Practices from First Settlement Physical Therapy, Inc. In addition, I agree to authorize First Settlement Physical Therapy, Inc., to release all information necessary to secure payment of benefits and use this signature on all claim submissions.

Signature: _____ **Date:** ____/____/____

Print Name: _____ **Relationship to patient:** _____