Patient Information

First Name _____ MI____ Last Name_____

Date of Birth_____ Age_____ SS# _____

Current Mailing Address_____

City_____ State_____ Zip _____ Phone # _____

Gender: ☐ Male ☐ Female ☐ Prefer not to answer Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Consent to Communicate by Email

By providing my email address, I consent to receive email communications regarding appointments, treatment, care coordination, billing, patient education, and information about health care-related services available through this practice and other affiliated providers and organizations within Alliance Physical Therapy Partners.

E-mail: _____

How did you hear about us?

☐ Doctor ☐ Insurance ☐ Mailing ☐ Family/Friend ☐ Google ☐ Social Media ☐ Returning Patient ☐ Other

Preferred method of contact: ☐ Phone ☐ Text/SMS ☐ Email ☐ I do not consent to email communications.

Preferred language: ☐ English ☐ Spanish ☐ Other_____ ☐ Need a translator

Insurance Information

Billing Information: ☐ I am billing my insurance for these services ☐ I do not have insurance or I would rather pay directly

Do you have Medicare? ☐ Yes ☐ No If yes, are you enrolled in Home Health? ☐ Yes ☐ No

Name of Home Health Agency & Phone Number_____ Date of Discharge_____

Have you had Physical Therapy anywhere else this calendar year? Y/N If yes, Where? How many visits?

Is this visit injury-related? ☐ Yes ☐ No If Yes, check the type: ☐ Work ☐ Car Accident

☐ Other/Personal Injury/Litigation Attorney Name & Phone Number _____

Health Insurance

Primary Insurance

Insurance Plan_____ Policy ID #_____ Group # _____

Insurance Phone_____ Policyholder Name_____ Relationship_____ DOB_____

Secondary Insurance

Insurance Plan_____ Policy ID #_____ Group # _____

Insurance Phone_____ Policyholder Name_____ Relationship_____ DOB_____

Physician Information

Referring MD Name _____ Phone_____ Next Appt_____

Employer Information

Employer Name/Address_____ Employer Phone_____

Emergency Contact Information

Name_____ Phone_____ Relationship_____

Authorization to Contact & Verbal Communication

I authorize Provider to release protected health information to the following individual(s). Cancellation of this Authorization must be made in writing.

Name_____ Relationship_____

Patient Health Questionnaire

Height:_____ft _____in Weight:_____lbs. Referring Physician: _____

Symptoms

What problem(s) are you being treated for today? (Describe type and location of symptoms)

What date (roughly) did your present symptoms start?_____

How did your problem(s) begin?

Have you had surgery for this injury? ☐ Yes ☐ No Number of surgeries_____ Type of surgery_____

PAIN ASSESSMENT

Please report a pain assessment on the scale below where 0 is no pain and 10 is the worst pain imaginable.

	N/A	1	2	3	4	5	6	7	8	9	10
Pain at Rest	○	○	○	○	○	○	○	○	○	○	○
Pain with Activity	○	○	○	○	○	○	○	○	○	○	○

FUNCTIONAL PROBLEMS

Please list any and all functional problems you currently have due to your diagnosis.

Have you had any of the following medical or rehabilitative for this injury/episode? Check all that apply:

- ☐ Chiropractor
- ☐ General Practitioner
- ☐ Massage Therapy
- ☐ MRI
- ☐ Occupational Therapy
- ☐ Neurologist
- ☐ Physical Therapy
- ☐ Speech-Language Pathology
- ☐ Orthopedist
- ☐ Emergency Room Care
- ☐ X-Rays
- ☐ CT Scan
- ☐ Other:

Check ALL conditions you have had below if applicable:

- ☐ Shortness of Breath/Chest Pain
- ☐ Coronary Heart Disease or Angina
- ☐ Pacemaker or defibrillator
- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Stroke/TIA
- ☐ Blood Clot/Emboli
- ☐ Epilepsy/Seizures
- ☐ Thyroid Trouble/Goiter
- ☐ Anemia
- ☐ Infectious Disease
- ☐ Diabetes
- ☐ Cancer or Chemotherapy/Radiation
- ☐ Arthritis/Swollen Joints
- ☐ Osteoporosis
- ☐ Sleeping Problems/Difficulties
- ☐ Emotional/Psychological Problems
- ☐ Vision or Hearing Difficulties
- ☐ Numbness or Tingling
- ☐ Dizziness or Fainting
- ☐ Weakness
- ☐ Weight Loss/Energy Loss
- ☐ Do you smoke?
- ☐ Are you pregnant? # weeks:
- ☐ Had a Major Surgery
- ☐ Allergies, please list:

Medications

Are you currently taking any prescription or non-prescription medications? ☐ Yes ☐ No If yes, list below:

Medication	How Much (Dose)	How Often	How Taken					
			Ointment	**Pill**	**Drop**	**Patch**	**Injection**	**Inhaler**
			☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐

Fall History

How many falls?_____If any, most recent occurrence: ☐ Last 6 weeks ☐ Last 6 months ☐ Last 12 months ☐ Over a year

Consent and Statement of Financial Responsibility

Patient Name:_____**Date:**_____**Med Rec #/Account#**_____

(Internal use only)

I hereby consent to the use and disclosure of my health information for treatment provided to me by of this physical therapy practice, payment for services provided by the provider or other health care providers and the operations of this physical therapy practice and others under certain circumstances. I understand that a more detailed explanation of the ways of this physical therapy practice may use and disclose my health information is contained in the Notice of Privacy Practices of the Provider, a copy of which has been provided to me.

PATIENT CODE OF CONDUCT

It is our goal to provide the highest quality of care in a safe environment. In our efforts to achieve this goal, we require all patients and visitors to refrain from any behavior that may pose a threat to the rights or safety of other patients and employees. Our patients agree to refrain from the following actions: (1) Bringing firearms or other weapons into the clinic; (2) Inappropriate behavior involving alcohol/substance use at time of treatment; (3) Attempting to intimidate or harass in any manner therapists, staff, or fellow patients; (4) Inappropriately touching therapists, staff, or fellow patients; (5) Racial or cultural slurs or other derogatory remarks associated with, but not limited to, race, language or sexuality; (6) Making verbal threats to harm another individual or destroy property through any medium of communication; and (7) Physical assault or inflicting bodily harm Violators of the abovementioned actions may be asked to leave the facility and/or be discharged from the clinic. My signature below indicates that I will support the clinic in its efforts to provide me with quality care in a safe environment and that I understand and accept the terms of the Patient Code of Conduct.

CONSENT FOR TREATMENT AND TREATMENT TERMS

I hereby consent to physical therapy, occupational therapy, and speech-language pathology services deemed medically necessary by my therapist and other health care professional involved in my care. I agree that any claim arising, directly or indirectly, from my treatment or appearance at the clinic must be resolved by mandatory arbitration to be conducted in Kent County, Michigan and governed by the American Arbitration Association healthcare payor/provider arbitration rules. I agree to waive the right to a jury trial for any such claim. I understand that my physical therapy program may include remote therapeutic monitoring (RTM). RTM services include telephone or video communications from a clinician to review my progress between in-clinic visits. This communication will allow my therapy team to monitor my progress and adjust my home exercise program as necessary to achieve my rehabilitation goals. I may receive complimentary access to the MedBridgeGo© software as well as education to use the app throughout my course of care.

CANCELLATION AND NO SHOW POLICY

Patients are expected to keep all scheduled appointments to maximize the benefits of their treatment plan. If a patient is unable to make a scheduled appointment, the patient is expected to give 24 hours advance notice or may be charged a cancellation fee of $60. Two (2) consecutive appointment no-shows may result in discontinuation of the current appointment schedule for the therapy involved. A pattern of frequent absences (cancellation and/or no-shows) will be considered problematic and result in discontinuation of services. Planned absences from scheduled therapy will not be considered cancellations or no-shows. If a patient provides notice of a planned absence, their on-going schedule may be placed on “hold” for up to two (2) weeks. A renewed prescription and appointment schedule may need to be arranged depending on the length of time which has passed.

TELEPHONE CONSUMER PROTECTION ACT NOTICE

You expressly consent and agree that, in order to discuss or provide services for your account(s) (the “Accounts”) or to collect amounts you may owe, this Physical Therapy Practice, and its officers, agents, affiliates, employees, first and third party debt collection agencies, and any affiliated or business associated service providers or vendors of any of these parties, associated therewith (collectively, “We”) may contact you by telephone at any telephone number associated with the Accounts, including wireless telephone numbers, which could result in charges to you. You confirm that any telephone number provide is associated with you and not a third-party. You expressly consent and agree that We may also utilize your information to contact you by letters or notices via mail, by sending emails, using any e-mail address you provide to us, by sending text messages or by pre-recorded or artificial voice or voice messages, via predictive or automatic dialing methods, systems, or devices, and pre-recorded or artificial voice announcements or prompts at any telephone number associated with the Accounts, including landlines, wireless or mobile telephone numbers, regardless of whether you incur charges as a result. We may contact you regarding billing, your account status or for marketing purposes, both our own internal marketing and marketing related to third parties.

Acknowledgment of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have received and agree with the Notice of Privacy Practices of this Physical Therapy Practice. I also acknowledge and understand that the clinic may use AI-assisted technology to record and transcribe my visit for documentation purposes. I understand that I may opt out of the recording at any time by notifying my therapist or clinical staff.

This Provider performs automated call, email, and text appointment reminders. The signature below also provides your consent for such reminders.

My signature below indicates that I understand the terms of treatment by this physical therapy practice.

Print Patient Name _____ Date _____

Patient Signature _____ Date _____

Guardian Signature (If needed) _____ Date _____

Printed Name of Above (if not patient) _____ Date _____

Third Party Coverage Questionnaire

Patient Name:_____ **Date:**_____ **Med Rec #/Account#**_____

(Internal use only)

INJURY LIABILITY QUESTIONNAIRE

The nature of your injury may alert your medical insurance company to potential liability. Completing this form in its entirety allows this physical therapy practice to provide a quick response to those inquiries and prevent delays in processing your claims.

Is this injury WORK-RELATED? ☐ Yes ☐ No Is this injury AUTO-RELATED? ☐ Yes ☐ No

Have you/do you intend to file a claim against a business or homeowner's insurance policy? ☐ Yes ☐ No

If you answered NO to the questions above, it is not necessary to complete the rest of this form.

Please sign and date the bottom of this page.

Injury Information

Date of injury/onset of condition/recent exacerbation?_____

Describe in detail how the injury occurred

Specific name and location where injury occurred (i.e.: store, restaurant, intersection, etc.)

Who is responsible for the accident? ☐ Self ☐ Other, describe _____

Insurance of Responsible Party _____ Claim # _____

Address_____

Adjuster Name_____ Adjuster Phone_____

The above information is accurate and true to the best of my knowledge. I agree to immediately notify this physical therapy practice with any change in this information.

Patient Signature _____ **Date** _____

When a patient is a minor or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required.

Legal Representative Signature _____ **Date** _____

Printed Name _____ **Date** _____

Description of Legal Representative Authority: ☐ Parent ☐ Medical Power of Attorney ☐ Other _____

Explain and Attach Documentation