

HERB KARPATKIN PHYSICAL THERAPY

Date _____

Patient Name _____ Male Female

LAST

FIRST

MIDDLE INITIAL

Name Preference _____ Birth date ____/____/____ SS# ____ - ____ - ____

Mailing Address _____

APT

CITY

STATE

ZIP

Primary Phone Number _____ Alternate Number _____

E-Mail _____ Occupation _____

Employer _____

Referred By _____ Doctor Friend Insurance Company

Status Minor Single Married Civil Union/ Partnership Divorced/Separated Widowed

Is this visit related to an accident? Yes No Date of accident ____/____/____

If yes, was it an auto accident work related slip & fall other _____

If an auto accident, were you the Driver Pedestrian Passenger

Have you retained an attorney due to this accident? Yes No

Attorney Name _____

Address _____ Phone _____

Other than No Fault/ Workers Comp do you have a secondary insurance? Yes No

Who is the guarantor? Self Spouse Parent Name _____ DOB ____/____/____

Insurance Company _____ Phone _____ Policy _____

Are you a dependent under the primary insurance (parents' insurance) Yes No If yes

What school do you go to? _____ Enrolled since ____/____/____

Employed? Yes No If yes, do you have insurance through your employer? Yes No

If yes, please give us a copy of card.

EMERGENCY CONTACT INFORMATION

Contact Name _____ Phone _____

Medical Doctor _____ Phone _____

MEDICARE PATIENTS

Please let us know if you are enrolled in a managed care Medicare program or a home health care program. This will allow us to bill the appropriate agency and avoid you from being financial liable for services rendered to you.

I am enrolled in a program not enrolled in a program

HEALTH HISTORY

Are you taking any of the following medications?

Nerve Pills Pain killers (including aspirin) Muscle relaxers Stimulants
 Blood Thinners Tranquilizers Insulin Other(s) _____

Do you have or ever had any of the following diseases or conditions?

<input type="checkbox"/> Y <input type="checkbox"/> N Heart Attack / Stroke	<input type="checkbox"/> Y <input type="checkbox"/> N Shingles	<input type="checkbox"/> Y <input type="checkbox"/> N Ulcers / Colitis
<input type="checkbox"/> Y <input type="checkbox"/> N Heart Surgery / Pacemaker	<input type="checkbox"/> Y <input type="checkbox"/> N Cancer	<input type="checkbox"/> Y <input type="checkbox"/> N Fainting/Seizures / Epilepsy
<input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur	<input type="checkbox"/> Y <input type="checkbox"/> N Frequent Neck Pain	<input type="checkbox"/> Y <input type="checkbox"/> N Sinus Problems
<input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Defect	<input type="checkbox"/> Y <input type="checkbox"/> N Emphysema / Glaucoma	<input type="checkbox"/> Y <input type="checkbox"/> N Asthma
<input type="checkbox"/> Y <input type="checkbox"/> N Mitral Valve Prolapse	<input type="checkbox"/> Y <input type="checkbox"/> N Anemia	<input type="checkbox"/> Y <input type="checkbox"/> N Diabetes / Tuberculosis
<input type="checkbox"/> Y <input type="checkbox"/> N Artificial Valves	<input type="checkbox"/> Y <input type="checkbox"/> N High / Low Blood Pressure	<input type="checkbox"/> Y <input type="checkbox"/> N Difficulty Breathing
<input type="checkbox"/> Y <input type="checkbox"/> N Alcohol / Drug Abuse	<input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric Problems	<input type="checkbox"/> Y <input type="checkbox"/> N Chemotherapy
<input type="checkbox"/> Y <input type="checkbox"/> N Venereal Disease	<input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic Fever	<input type="checkbox"/> Y <input type="checkbox"/> N Lower Back Problems
<input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis	<input type="checkbox"/> Y <input type="checkbox"/> N Severe/Frequent Headaches	<input type="checkbox"/> Y <input type="checkbox"/> N Artificial Bones / Joints
<input type="checkbox"/> Y <input type="checkbox"/> N HIV+ / Aids	<input type="checkbox"/> Y <input type="checkbox"/> N Kidney Problems	<input type="checkbox"/> Y <input type="checkbox"/> N Arthritis

Please list any other serious medical condition(s) you have or ever had _____

Please list anything that you may be allergic to _____

List previous surgeries/treatment with dates _____

List any past serious accidents with dates _____

Family health history _____

Do you take supplements or vitamins? Yes No **Do you exercise?** Yes No

Are you on a special diet? Yes No Since ____/____/____

Do you smoke? Yes No How Much? _____ How Long? _____

Are you wearing Heel lifts Sole lifts Inner soles Arch supports

Women Birth Control? Yes No **Pregnant?** Yes No **How long?** ____ weeks **Nursing?** Yes No

- We invite you to discuss with us any questions regarding our services. The best health services are based on understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit unless other arrangements have been made with the business manager. If the account is not paid in full within 90 days of the date of service and no payment arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your patient account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and/or managed care organization to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date _____

Adult Patient Parent or Guardian Spouse

ASSIGNMENT OF BENEFITS
HERB KARPATKIN PHYSICAL THERAPY

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carriers payments. The patient is responsible and will be billed for any services not covered by their insurance carrier.

Assignment of Benefits

I hereby assign all medical benefits to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Herb Karpatkin Physical Therapy for medical services rendered to myself and/or dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Herb Karpatkin Physical Therapy to (1) release any medical information necessary to insurance carriers regarding any illness and treatments; (2) process insurance claims generated in the course of examination of treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Herb Karpatkin Physical Therapy on behalf of myself and /or my dependent, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date the services are rendered and I agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Patient/Responsible Party Signature

Date

Witness

Date

LATE CANCELLATION/ NO SHOW POLICY

If you have to cancel a scheduled appointment we ask that you do so within 24hrs prior to your scheduled appointment, or YOU will be subject to a \$55 late cancellation/no show fee. We ask that you do so in courtesy to your fellow clients who may use that time slot for their physical therapy treatment. This policy will help us to keep a more efficient schedule. If you fail to attend 3 scheduled appointments without prior notification Herb Karpatkin Physical Therapy reserves the right to discharge you from your physical therapy program.

Patient Signature

Date