THREE RIVERS
PHYSICAL THERAPY

Name:_____
Last First Middle Initial

Address:_____

City:_____ State:_____ Zip:_____

Gender: Male ☐ Female ☐ Age:_____ Date of Birth:_____

Primary Phone: (_____)_____ appt text reminders to this phone? Yes ☐

Secondary Phone: (_____)_____ appt text reminders to this phone? Yes ☐

Email:_____ appt email reminders to this email? Yes ☐

Referring Physician: _____

Next appointment with Referring Physician_____

MEDICARE PATIENTS: Are you currently receiving home health services? Yes ☐ No ☐

If yes, name of the Agency providing services_____

ALL NEW PATIENTS – Please complete the following section:

Primary Insurance Company:_____

Policy Holder's Name:_____ Date of Birth:_____ Patient Relation to Policy Holder_____

Secondary Insurance Company:_____

Policy Holder's Name:_____ Date of Birth:_____ Patient Relation to Policy Holder:_____

Please complete this section ONLY IF On The Job Injury / Worker's Compensation Claim:

Insurance Name:_____ Claim #_____

Employer:_____ Date of Injury: _____

Case Manager:_____ Phone No:_____

Employer Phone No:_____

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Symptom Sheet

Name_____ Date_____ Age_____

Occupation_____ Employer_____

Describe your problem_____

_____

Was this from an accident? No ☐ Yes ☐ Date_____

If ***yes***, was it related to: Auto_____ On the job injury_____ Other_____

Have you had this problem before? Yes ☐ No ☐

Have you had physical therapy **OR** massage this year? Yes ☐ No ☐ If ***yes***, where? _____

What time of day are your symptoms worse?_____ better?_____

Do you have problems *going* to sleep? Yes ☐ No ☐ *Staying* asleep? Yes ☐ No ☐

Do you have any of the following symptoms? (**circle all that apply**)

Headaches Weakness Numbness Tingling Dizziness

Pain Muscle Spasms Decreased Motion Other_____

Which of the following activities increases your symptoms? (**circle all that apply**)

Coughing Sneezing Swallowing Lying on back Lying on front

Urinating Bowel Movements Bending Forward Other_____

Which of the following decreases your symptoms? (**circle all that apply**)

Heat Ice Massage Exercise

Have you had any diagnostic tests taken for this problem? (**circle all that apply**)

X-rays MRI CT Scan Bone Scan Nerve Conduction Other:_____

Are you taking medications for this problem?_____

Do you have any other medical conditions?_____

Are you taking any medications for these conditions?_____

Are you currently off work due to your Physical Therapy problem? Yes ☐ No ☐ Not employed ☐

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INFORMED CONSENT

I consent to receiving physical therapy services which are deemed medically necessary by my referring and/or primary care physician. I authorize the release of medical information to my referring physician and insurance company.

I am aware that Three Rivers Physical Therapy will submit charges for services to my insurance company unless I make other arrangements. I hereby assign all medical benefits to be paid directly to Three Rivers Physical Therapy. I realize I am responsible for all charges incurred, regardless of payment by my insurance company. Any charges not paid by my insurance company will become my responsibility within 60 days. If it becomes necessary for my account to be assigned to a collection agency, I agree to pay all collection costs.

I assign any proceeds from any cause of action, whether from a court award or settlement, in the hands of my attorney, the responsible party, or the insurance carrier for the responsible party to Three Rivers Physical Therapy. I authorize and direct my attorney to pay all outstanding bills to Three Rivers Physical Therapy from the proceeds of any settlement.

I understand that there may be a twenty dollar ($ 20.00) handling fee for "no shows" and cancellations of more than 2 appointments without providing twenty-four (24) hour notice.

I authorize the use of this signature on all insurance submissions.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

A copy of Three Rivers Physical Therapy's **Notice of Privacy Policies** has been made available to me, detailing how my information may be used and disclosed as permitted under federal and state law. I permit a copy of this authorization to be used in place of the original. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

Restriction(s): _____

_____

_____ _____

Patient or Representative Signature **Date**

If not signed by patient, please indicate relationship to patient (e.g., spouse, parent)

Relationship: _____