FINANCIAL QUESTIONNAIRE

Patient Information

Name:____ Birth Date:_______________________________

Address: ____

City: ____ State: ____________ ZIP: _______________

Phone: Home: ( )________________________ Work: ( )__________________________ Ext:_____________

Name Of Spouse: _______________________________ Spouses Phone Number: ( )___________________________

Emergency Name and Phone Number:____

Social Security Number: _____________________________ Drivers License Number: _____________________________

Primary Insurance Information

Type Of Claim: ___ Workers Comp ___ Motor Vehicle ___ Private Insurance ___ Other

Name Of Insurance: ____

Address: ____

City: ____ State: ____________ ZIP: _______________

Phone: ( )___________________ Claim / Group Number:____________________ ID Number: ____________________

Name Of The Insured:____ Birth Date Of Insured:______________________

Employer Of The Insured:____

Secondary Insurance Information

Name Of Insurance: ____

Address: ____

City: ____ State: ____________ ZIP: _______________

Phone: ( )___________________ Claim / Group Number:____________________ ID Number: ____________________

Name Of The Insured:____ Birth Date Of Insured:_____________________

Employer Of The Insured:____

Employment Information

Name Of Employer: ____ Phone: ( )_________________Ext:__________

Address: ____

City: ____ State: ____________ ZIP: _______________

PHYSICAL THERAPY ASSOCIATES
FINANCIAL AGREEMENT

PLEASE READ CAREFULLY

1) As a service to you this office will bill your insurance company. We ask that all insurance companies pay us directly.

2) I authorize ______________________ Insurance Company to make payments directly to **Physical Therapy Associates.** If my current policy prohibits direct payment, I hereby instruct and direct you to make the check out to me and mail it to **Physical Therapy Associates.**

3) I understand that as the patient or guardian I am responsible for all charges whether or not paid by insurance.

4) Payment is expected within 30 days after the first statement is sent and is considered past due if a second statement is sent. Balances older than 60 days are subject to additional collection fees and interest charges of 1.5% per month.

5) **IT IS IMPORTANT THAT YOUR APPOINTMENTS BE KEPT.** We ask that at least a two hour notice be given if you cannot keep your appointment. There is a $10.00 service charge for an appointment missed without notice.

6) If the patient is a minor, a parent or guardian must be present at the first visit to sign a treatment authorization and payment agreement before the patient can be seen.

I HAVE READ THE ABOVE PAYMENT POLICIES AND AGREE TO THE TERMS OF THESE POLICIES. IN THE EVENT LEGAL ACTION SHOULD BECOME NECESSARY TO ENFORCE PAYMENT OF ANY CHARGES, I AGREE TO BE RESPONSIBLE FOR AND PAY ALL REASONABLE ATTORNEY'S FEES AND COURT COSTS INCURRED.

CONSENT FORM

I authorize **PHYSICAL THERAPY ASSOCIATES** to provide physical therapy services to myself or my dependent. I further authorize **PHYSICAL THERAPY ASSOCIATES** to release any information in the course of my examination or treatment to my physician, insurance company, lawyer, or other allied health professionals.

DATE: ___________________ SIGNED: _______________________________________

Patient or Guardian

WITNESS SIGNATURE: _____________________________

PATIENT QUESTIONNAIRE

Personal History

Name:____Age:______ Male / Female Date Of Evaluation:_________________

Place Of Employment:_________________________________How Long?___________ Job Title:_____________________________

Job Activities Required: ____

____

Physicians:

Primary Care Physician:___________________________________ Specialist:______________________________________

Chiropractor:____ Other: ____

Please Describe Any Exercise Programs
You Perform Routinely:____

____How Often? _______________________

Have You Been Able to Continue Your Exercises? Yes No If No, Why?_____________________________________

Past Medical History

Have You Had A Similar Injury, Surgery Or Symptoms In The Past? Yes No If Yes, Please Describe: ____________

____

Have You Had Physical Therapy In The Past? Yes No
If Yes, Please Describe
Where And Why:____

Have You In The Past Or Are You Currently Having Chiropractic Treatments? Yes No
If Yes, Please Describe
Where And Why:____

Medications:

Please List Medications You Take Routinely:____

____

Please List Medications You Are Taking For The Current Problem:____

____

Do You Currently Use Any Medical Devices? (such as a TENS Unit, Orthotics, Braces, etc.) Yes No
If Yes, Please Describe
The Device:____

Please Indicate Any Other Medical Problems: ___ Pregnancy ___ Diabetes ___ Heart Disease ___ Cancer

Other:____

____

Current Information

Please Describe Your
Current Symptoms:____

____

Did You Have An Injury? Yes No Did You Have Surgery? Yes No

If Yes, Please Describe:____

____Date Of Injury / Surgery ________________

If No, Please Describe When And Why
The Symptoms Started:____

How Have Your Symptoms Changed
From When They First Started?____

What Activities Increase Your Symptoms?
(such as sitting, lifting, etc.)____

What Activities Decrease Your Symptoms?
(such as lying down, medication, heat / ice, etc.)____

Day Pattern

In The Morning My Symptoms Are: ___ Better ___ Worse ___ No Change
If Your Symptoms Change,
Please Describe How :____

In The Evening My Symptoms Are: ___ Better ___ Worse ___ No Change
If Your Symptoms Change,
Please Describe How:____

Sleeping: ___ I Sleep Through The Night ___ I Awaken Frequently.
If You Awaken Frequently,
Please Describe Why:____

Are There Activities You Can
No Longer Perform?____

Testing

Please Complete Below As It Applies To You.

MRI Scan ___ No ___ Yes Results:____
X-Ray ___ No ___ Yes Results:____
CAT Scan ___ No ___ Yes Results:____
Bone Scan ___ No ___ Yes Results:____
Other ___ No ___ Yes Results:____

Goals

Please List Your Goals For Physical Therapy: (such as decreasing symptoms, changing activity levels, solving problems, etc.)

____

____