Name: _____

Primary Care Doctor: _____

Primary Insurance Member Number: _____

Are you currently taking any medications? Please list:

_____

Please list previous orthopedic injuries and surgeries (if applicable): Date?

_____ _____

Have you ever had physical therapy before? Injury type? Date?

_____ _____

Which of the following medical services have you had for your ***current*** injury?

____Emergency Room Care
____General/Family Practitioner/Internist (circle one)
____Orthopedic
____Neurologist
____Rheumatologist
____Physiatrist
____Chiropractor
____Acupuncture/Massage Therapy

____X-Ray
____MRI
____CT Scan
____Blood-workup
____EMG-EEG
____Mylogram/Arthrogram
____Other:_____

Please check all that apply:

____Angina/Chest Pain
____High Blood Pressure
____Heart Attack date?_____
____Heart Surgery date?_____
____Stroke/TIA date?_____
____Blood Clot date?_____
____Cancer date?_____
____Chemo/Radiation date?_____
____Currently Pregnant
____Dizziness/Fainting
____Loss Of Balance
____Chronic Pain>6 weeks
____Vision/Hearing Loss
____Eating Disorder
Do you smoke? ___N ____Y PPD

____Asthma/Shortness of Breath
____Emphysema/COPD
____Metal Implants/Pins
____Diabetes/Neuropathy
____Gout
____Osteoarthritis
____Rheumatoid Arthritis
____Osteoporosis
____Epilepsy/Seizures
____Bowel/Bladder Dysfunction
____Attention/Concentration Loss
____Memory Loss
____Chronic Fatigue
____Emotional/Psychological

VOCATIONAL HISTORY
Occupation_____

____Working without Restrictions
____Working with Restrictions
____Disabled/Disability
____Unable to work due to injury
____Retired, prior occupation:_____

Date returned to work ___/___/_____

Date last worked ___/___/_____

Hobbies/Recreation_____

Consent to Treat: I understand that by signing I am giving my permission for evaluation and treatment by **Specialized Orthopedic Physical Therapy** and that I have the right to refuse any procedure after having the risks and benefits explained to me.

Cancellation Policy: I understand that I am to give Specialized Orthopedic Physical Therapy 4 hours notice of any cancellations. There is an answering machine for my convenience which is available to me at any time. Excessive cancellations/ no shows will lead to cancellation of all future scheduled appointments and notifications to my physician or adjuster. **I understand that I am subject to a cancellation fee of $20.00 for each same day cancellation or no show appointment.**

HIPPA Policy: I acknowledge that **SPECIALIZED ORTHOPEDIC PHYSCIAL THERAPY** has posted a copy of their Office Policies and Health Information Privacy Practice Agreement (HIPAA) regarding their policies and procedures concerning my Protected Health Information (PHI) in an easily accessible spot. I also acknowledge that copy is available for download from their website, www.soptri.com. I agree to release authorization to Specialized Orthopedic Physical Therapy to use my PHI as deemed necessary for treatment, billing and the purposes mentioned in the notice.

Payment Policy: Co-pay/Co-insurance and Deductibles not met are due at time service is rendered. If you cannot settle your account at the time of each visit, special arrangements must be made in advance with our office. If balance is 60 days past the original due date, a 10% penalty will be added. All unpaid balances 90 days or older will be considered for third party collections. If your insurance requires a referral from your Primary Care Physician, we can request one as a courtesy. Ultimately, it is your responsibility to obtain this referral.

I would like to keep a credit card on file, to be charged weekly, for any co-pays or coinsurance owed by me. **(We accept Visa, MasterCard or Debit Cards)**

Please see Insurance Verification/Financial Agreement for your benefit detail.

PLEASE CHARGE WEEKLY my co-pay or coinsurance to my_____
Card#_____

Name on Card:_____

Expiration date:_____ Security Code:_____

The above information is correct to the best of my knowledge. I have read, understand and agree to this statement in its entirety.

Signature:_____ Date:_____

Signature of responsible party if minor (under 18 years of age):_____