FARMINGTON PHYSICAL THERAPY
Rooted in Recovery, Focused on You.

First Name: MI: Last Name:

Preferred Name:

Address: City/State

Zip Code: Date of Birth: SSN:

Home Phone: ☐ ( ) Mobile: ☐ ( ) Work: ☐ ( )
*please check box for the phone number(s) we have permission to leave voice messages regarding treatment dates and time

Email Address:

What sex were you assigned at birth? ☐ Male ☐ Female

What is your gender? ☐ Male ☐ Female

Employer: Occupation:

Emergency Contact: Relationship: Phone Number ( )

Health Insurance(s): Primary: Secondary

Subscriber Name: DOB: Relationship:

Primary Care Physician (PCP) Practice: City/State:

Referred by: Practice: City/State:

Reason for Today's Visit: Date of Injury/Surgery:

Have you had previous PT for this injury? **Y / N** DatesofService: to

Where did you go for previous treatment? # of Visits:

How did you hear about us? ☐ Friend ☐ Physician ☐ Radio ☐ Web ☐ Newspaper ☐ Other

Is this a Worker's Compensation Claim? Y / N Claim Number:

Worker's Compensation Insurance Company:

Employer: Employer Contact Person/Phone Number:

Is this an Automobile Insurance Claim? Y / N State Accident Occured:

Party Responsible for Payment:

Automobile Insurance Company: Claim Number:

Attorney Involved: Y / N Name: Phone Number:( )

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Past History (please circle)

Asthma COPD Pulmonary Disease
High Blood Pressure High Cholesterol
Vascular Disease Arrhythmia Palpitations
Heart Attack Pacemaker Stroke

Other Cardiac Disease _____
Diabetes Type 1 / Type 2 Hypoglycemia
Cancer (please specify)_____
Depression Anxiety Seizures
Osteoporosis Osteopenia
Fractures (please specify)_____
Pregnancies/Births _____C-Sections_____
Injuries (please specify)
_____
Allergies (please specify)
_____
Surgeries (please specify)
_____
_____
_____

Other_____
_____
_____
_____

Medications

Name Dosage Frequency Route

_____
_____
_____
_____
_____

Family History

Cancer Cardiovascular Disease Diabetes

Currently, are you or do you have:

Pregnant Chest Pain Infection HIV TB
Hepatitis Light Headedness Dizziness
Fatigue Loss of Consciousness Swelling
Fever Night Sweats Weakness
Numbness Tingling Shortness of Breath
Loss of Bowel or Bladder Control Night Pain
Recent Weight Gain or Loss (more than normal)

Do You Use Tobacco Products? Yes No

How much per day? _____ How long? _____

Rate Your Quality of Health

Poor Fair Good Excellent

Please use the diagram below to indicate the symptoms you have experienced today.

Key:

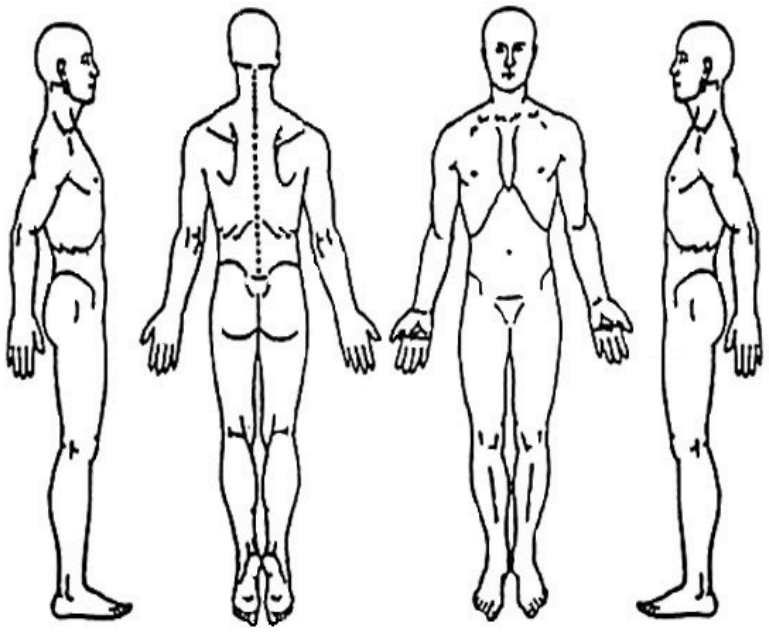
Pins/Needles = O O O

Burning = X X X X X

Stabbing = / / / / /

Numbness = N N N N

Deep Ache=ZZZZ



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By signing below I am acknowledging and agreeing to the following:

CONSENT TO EXAMINATION AND TREATMENT: I consent to examination and/or treatment by the physical therapist, assistant, aide, medical technician and/or student of me or the minor patient listed below. This may include, but not be limited to exercise, hands on treatment, or use of medical tools and devices whose purpose will be explained prior to use. I understand that the provider will take into consideration my/minor patient's conditions and use his or her best judgment for my/minor patient's safety to help achieve the goals for the treatment. I understand that I may stop my request for treatment before any procedure or test.

CANCELLATION POLICY: We, at Farmington Physical Therapy, will make every effort to schedule your therapy appointments at a time that is convenient for you. In the event that you cannot attend a particular scheduled appointment, **we ask that you call Farmington Physical Therapy at least 24 hours prior to that appointment to cancel and/or reschedule that appointment. If you do not call to cancel or do not show for a scheduled appointment, you could be charged a $50 fee for a missed appointment.**

If you miss 3 scheduled appointments, we reserve the right to discharge you from therapy. In order to resume therapy after such time you will need to see your physician, obtain another prescription and call us to schedule a re-evaluation.

Also, if you are more than 15 minutes late for your appointment, it will be left to the discretion of your therapist whether or not you will be treated at that time.

I give permission for Farmington Physical Therapy to contact me at home or at my work for any therapy/insurance related issue.

If you have any questions about this policy, please do not hesitate to ask. Thank you in advance for your cooperation.

Signature of patient	Name of Patient (please print)	Date
Parent/Guardian Signature	Name of Parent/Guardian (please print)	Date

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BILLING AND PAYMENT:
If I/minor patient has health insurance coverage, I agree to assign the insurance benefits to Farmington Physical Therapy for payment of the services and supplies provided to me/minor patient. Farmington Physical Therapy (and its entities) will bill my/minor patient's primary and secondary insurance companies for the treatment and supplies provided.

I hereby agree to the following:

- If my insurance determines that the service is not "Medically Necessary, Experimental, Investigational and/or not a Covered Service" as defined in my insurance plan documents, even if it is not on the non-covered list of services.
- **I agree to pay Farmington Physical Therapy for the balance of any charges not covered by insurance (this includes any deductible, co-payments and coinsurance), for the full amount of the bill for any services that I receive not covered by my insurance(s), in the event of a workers' compensation denial, and regardless of any ongoing legal cases related to my reason for attending physical therapy.**

- It is Farmington Physical Therapy's policy to store credit card information on file. Please inform our Office Staff, should you wish your credit card information to be removed.
- I understand that it is my responsibility to obtain any preauthorization or referral required by my insurance carrier.
- It is Farmington Physical Therapy's policy to collect $50 towards your deductible at time of service; the remainder of balance will be due once your insurance carrier processes the claims.
- I understand I will be charged a $25.00 fee for any and all checks returned from the bank for insufficient funds.

MEDICARE or MEDICAID BENEFICIARIES:
- I certify that the information given by me for payment under Medicare (Title XVIII of the Social Security Act) and/or Medicaid (Title XIX of the Social Security Act) is correct.

NOTICE OF PRIVACY PRACTICES: I acknowledge that I have received Farmington Physical Therapy's Notice of Privacy Practices, and if I wish to obtain another copy, one shall be provided to me.

NO GUARANTEE OF OUTCOME: I understand that no guarantees have been made to me about the outcomes of my treatment.

Signature of patient	Name of Patient (please print)	Date
Parent/Guardian Signature	Name of Parent/Guardian (please print)	Date