Patient Information Form

Name: ___________________________________
Address: _________________________________
City & Zip Code: ___________________________
Phone (Home): ____________________________
(Wk/Cell): ____________________________
*E-Mail: _________________________________
(*for home exercise, surveys and newsletters)
In Case of Emergency Contact: _______________
Phone Number: ____________________

Date of Birth: __________________
Marital Status: M S D W O
Gender: Male ☐ Female ☐ Other ☐
Are You: Employed ☐ Not Employed ☐
Employer: _________________________________
Occupation: _______________________________
Leisure Activities: ___________________________
Primary Insurance: ___________________________
Secondary Insurance: _________________________

Medical History

Allergies: List any medication(s) you are allergic to: ___________________________________

Are you Latex Sensitive? YES NO

List any allergies we should know about

Please check any of the following whose care you are under:

__ Medical Doctor
__ Osteopath
__ Naturopath
__ Chiropractor
__ Psychiatrist/Psychologist
__ Dentist
__ Physical Therapist
__ Other

During the past month have you been feeling down, depressed, or hopeless? YES NO

During the past month have you been bothered by having little interest or pleasure in doing things? YES NO

Reason for today's visit: ____

Who referred you to this clinic? ____

How did you hear about us? Newspaper ☐ Facebook ☐ Online Search ☐ Returning Patient ☐ Other ☐

Family member who has received care at this clinic? ____

Who is your primary care provider and when did you last see them? ___________________________________

If these symptoms or injury is related to an accident, was it: Auto Accident ☐ Job-Related ☐ Other ☐

Today's date: ______________ Date of injury or date symptoms began: ________________________

<u>Have you EVER been diagnosed as having any of the following conditions?</u>

YES NO Cancer
If Yes, what kind: _______________
YES NO Chemical Dependency (e.g. alcoholism)
YES NO Heart Problems
If Yes, what kind: _______________
YES NO Circulation Problems
YES NO Asthma
YES NO Stomach Ulcer
YES NO Thyroid Problems
YES NO Diabetes
YES NO Multiple Sclerosis

YES NO High Blood Pressure
YES NO Rheumatoid Arthritis
YES NO Depression
YES NO Hepatitis
YES NO Tuberculosis
YES NO Stroke
YES NO Kidney Disease
If Yes, what kind: _____________________
YES NO Blood Clots
YES NO Osteoporosis
YES NO Other _____________________________

Surgeries / Hospitalizations (Include Date and Reason)

1. ____
2. ____
3. ____
4. ____

Please describe any significant injuries: (e.g. fractures, dislocations, sprain) and the approximate date of injury:

	DATE:	INJURY:		DATE:	INJURY:
1.	_______	______________________	4.	_______	______________________
2.	_______	______________________	5.	_______	______________________
3.	_______	______________________	6.	_______	______________________

Has anyone in your immediate family (e.g. parents, siblings) ever been treated for the following?

YES NO Diabetes

YES NO Heart Disease

YES NO Stroke

YES NO Inflammatory Arthritis
(Rheumatoid, ankylosing)

YES NO Cancer

YES NO Alcoholism (Chemical Dependency)

YES NO Depression

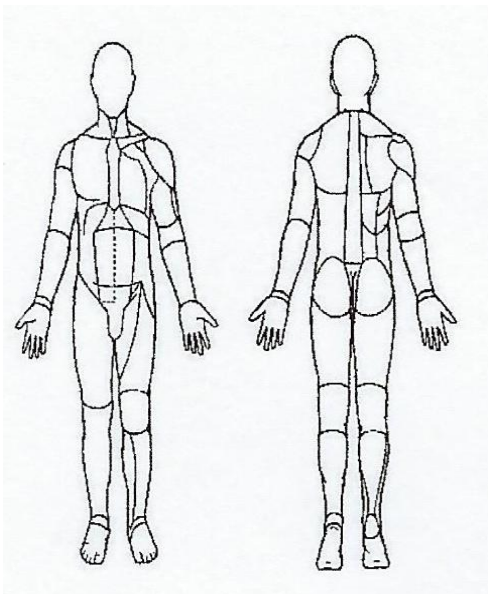
YES NO Kidney Disease

YES NO High Blood Pressure

Please describe and date all of the selections you marked above:

____

____



Please mark on the figure front and back where you have pain. Use the following marks to describe the type of pain you are having

>>> means sharp, lancing, or stabbing

+++ means aching/throbbing

ooo means numbness or tingling

On a scale of 0 to 10, 0 representing no pain, and 10 representing the worst pain possible, what number is your pain level:

At its worst? ___

At its best? ___

Right now? ___

I have completed this information truthfully and completely to the best of my knowledge, I voluntarily consent to physical therapy treatment at Corebalance Therapy, LLC. I understand that I may withdraw at any time. I understand that I can choose a different physical therapist at any time.

X________________________________ ________________

Patient's Signature **Date**

Billing Practices:

1. INSURANCE BILLING: I understand and agree that CoreBalance Therapy will bill my health insurance company as a service to me, provided they are under contract with my particular insurance company. I am aware that reimbursement is dependent on my particular plan with that company, including deductibles, contracted rates and allowed amounts, I understand that I am ultimately responsible for payment of services received at CoreBalance Therapy.

2. INSURANCE BENEFITS: I understand and agree that CoreBalance Therapy will attempt to acquire benefits information and required authorization prior to my first visit and make the best attempt to inform me of the benefits I should expect for the services provided at CoreBalance Therapy. I am aware that I am ultimately responsible for understanding my benefits as they are delineated in my contract with my health insurance company.

3. APPOINTMENT CANCELLATIONS AND NO SHOWS: We ask that you notify us within 24 hours of your appointment if you cannot attend, So that we may accommodate other patients. CoreBalance Therapy reserved the right to bill a **$30 NO SHOW FEE** if we are not notified in advance that you cannot make your scheduled appointment. Consistency in treatment is important to your rehabilitation outcome, therefore multiple cancellations may result in termination of your treatment or loss of prime (desired) schedule time

4. PAYMENT PROGRAM: I am aware that in individual circumstances, Corebalance Therapy will accept monthly payments as determined and agreed upon by both parties. If you are interested in this program please discuss this with us at your initial evaluation.

5. COLLECTIONS: I understand and agree that CoreBalance Therapy utilizes the services of a collection agency and unpaid balances greater than 30 days past due will be considered for collections. I understand that I am responsible for all collection costs, in the event that my account is referred to a collection agency for non-payment.

I understand that I am responsible for payment of all physical therapy charges due CoreBalance Therapy LLC. I understand that CoreBalance LLC will bill my insurance company for me. I authorize the release of any medical or other information necessary to process this claim. I request payment of insurance benefits to CoreBalance Therapy LLC.

X________________________________ ________________

Patient's Signature **Date**

Patients Acknowledgement of Receipt of Privacy Information

I have been offered the CoreBalance Therapy, LLC Notice of Privacy Practices. This Document informs me of my privacy rights and the privacy practices of CoreBalance Therapy, LLC.

X________________________________ ________________

Patient's Signature **Date**