Patient Information:

Patient Name: ___________________________ DOB: _____________________________

Patient Parent/Guardian/Caretaker: ____

Home Address: ____

City: ___________________________________ State/Zip: _________________________

Home/Cell Phone: ____

Email Address: ____

Emergency Contact Name & Phone Number: ____

Primary Care Physician: ____

Referring Physician: ____

How did you hear about us? ____

Insurance Information:

Primary Insurance: _________________________ Subscriber ID: ______________________

Subscriber Name: __________________________ Relation to Patient: __________________

Subscriber DOB: ___________________________

Secondary Insurance: _________________________ Subscriber ID: ______________________

Subscriber Name: __________________________ Relation to Patient: ____________________

Subscriber DOB: ___________________________

Welcome

Thank you for choosing Limitless Physical Therapy Specialists! We look forward to serving you. Please take some time and review our policies. We would be happy to answer any questions you may have.

Informed Consent

I consent to, or I am a guardian signing for the patient named on this form to be examined and treated by LIMITLESS PHYSICAL THERAPY SPECIALISTS, P.C. or a representative thereof.

Assignment of Benefits

I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other health/medical plan to issue payment check(s) directly to LIMITLESS PHYSICAL THERAPY SPECIALISTS, P.C. for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any.

Financial Policy

I have requested medical services from LIMITLESS PHYSICAL THERAPY SPECIALISTS, P.C. on behalf of myself and/or my dependents. In doing so, I agree that I become fully financially responsible for all charges incurred in the course of the treatment authorized regardless of my insurance status. I further understand that fees are due on the date that the services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement.

I understand that if my insurance company requires a copayment, that copayment is my responsibility and payment is due at the time of service.

I understand that if I have a high deductible insurance, I will be charged the estimated cost at the time of the visit (minimally $50.00).

I understand that a $25 fee will be charged for all returned checks.

Authorization to Release Information

I authorize LIMITLESS PHYSICAL THERAPY SPECIALISTS, P.C. to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I hereby authorize LIMITLESS PHYSICAL THERAPY SPECIALISTS, P.C. to disclose a message pertaining to my appointments to a family member via email, or a message on my home/cell phone.

No Show/Cancellation Policy

At LIMITLESS PHYSICAL THERAPY SPECIALISTS, P.C. we are committed to providing you with excellent, quality physical therapy services. We ask that you make every effort to arrive on time for scheduled appointments. Please provide 24 hours' notice for appointment cancellations. **NO SHOW visits will be charged a $50.00 fee**. This fee will be assessed regardless of insurance type and payment is the responsibility of the patient, not the insurance company.

Authorization For Use Or Disclosure Of Patient Photographic/Video Images

I understand that it is common practice at LIMITLESS PHYSICAL THERAPY SPECIALISTS, P.C. to have photos taken that may be used for marketing purposes. I also understand that prior to a photo being taken, I will be asked for verbal consent. **If verbal consent is given,** then I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for marketing purposes by LIMITLESS PHYSICAL THERAPY SPECIALISTS, P.C.

I understand that I may revoke this authorization at any time, but such revocation must be in writing. Revocation affects disclosure moving forward and is not retroactive. This authorization expires upon written notice.

I understand that the practice cannot condition treatment on whether or not I sign this authorization.

I have read and agree to the Informed Consent, Assignment of Benefits, Financial Policy, Authorization to Release Information, No Show/Cancellation Policy, and the Authorization for Use or Disclosure of Patient Photographic/Video Information. A photocopy of this document is to be considered as valid as the original. In the event the patient is a minor, by signing this document, I am agreeing to the statements listed above.

____ Patient Name (Printed)

_________________________ Date

____ Patient **- or -** Guardian's Signature

__________________________ Guardian's Relationship to Patient

PAST MEDICAL HISTORY FORM

Patient Name: ____ DOB: ________/________/_______

What is your main complaint and in what area is the injury located:

____

____

Please list **ALL current** medications (prescribed and over the counter) and what you are taking them for:

____

____

Allergies:____

Are you presently working? ☐ Yes ☐ No Date of next physician's visit: ______/______/______

Date of injury/onset: ________/_______/_______

Have you ever had these symptoms before? ☐ Yes ☐ No

Check which apply to your current condition:

☐ work-related injury	☐ recurrence of previous injury	☐ motor vehicle accident
☐ injury related to lifting	☐ injury related to falling	☐ athletic/recreational injury
☐ cause unknown	☐ other: ___________________	

Have you had any operations or hospitalization in the past five years? IF yes, please explain:____

____

Have you ever had any x-rays, sonograms, CT scans, MRI or other imaging done recently? ☐ Yes ☐ No

If yes, What? ________________________________ When? _______________________________ Results? ________________________

If female, are you pregnant? ☐ Yes ☐ No

Have you ever had a head Injury? ☐ Yes ☐ No

Do you have, or have had any of the following:

	Yes	No		Yes	No
Diabetes	☐	☐	Hypoglycemia	☐	☐
Chest Pain/Angina	☐	☐	Osteoarthritis	☐	☐
High Blood Pressure	☐	☐	Osteoporosis	☐	☐
Heart Disease	☐	☐	Hernia	☐	☐
Heart Attack	☐	☐	Seizures	☐	☐
Heart Palpitations	☐	☐	Metal Implants	☐	☐
Pacemaker	☐	☐	Dizziness/Fainting	☐	☐
Headaches	☐	☐	Fractures	☐	☐
Problems Kidney	☐	☐	Surgeries	☐	☐
Cancer	☐	☐	Skin Abnormalities	☐	☐
Stroke	☐	☐	Nausea/Vomiting	☐	☐
Bowel/Bladder Abnormalities	☐	☐	Ringing in your ears	☐	☐
Urine Leakage	☐	☐	Rheumatic Arthritis	☐	☐
Asthma/Breathing Difficulties	☐	☐	Smoking	☐	☐
Liver/Gallbladder Problems	☐	☐	Other	☐	☐

If you answered yes to any of the items above, please briefly explain and give the date. Include other pertinent information regarding your past medical history:

____

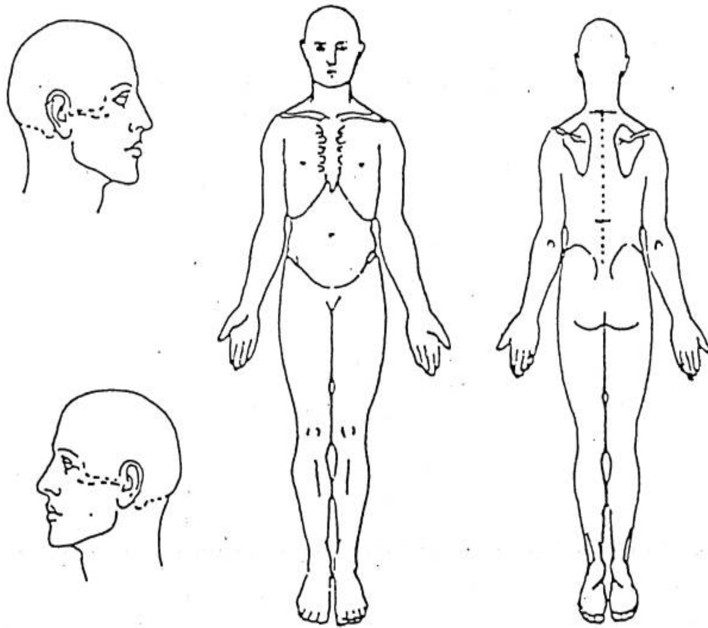
____

Is there anything else in your medical history that you want us to know about?

____

Do you participate in any sports, exercise programs or activities on a regular basis? □ Yes □ No

Please indicate below where your symptoms are located using key:



KEY

Numbness	= = = = = =
Pins & Needles	0 0 0 0 0 0
Burning Pain	XXXXXX
Stabbing Pain	/ / / / / / / / /

Circle any other words that describe your symptoms:

Knifelike	Dull	Burning
Aching	Throbbing	Boring
Heaviness	Discomfort	Sharp
Stinging	Tingling	Stabbing

Other:____

If you are having pain, please rate the intensity of your pain on a scale of 0 to 10, with 0 being no pain and 10 being the worst pain possible.

Worst pain since onset: __________________ Least pain since onset: ____________________Current pain: ______________________

Are your symptoms getting: **worse** **better** **the same** since your injury? Please Circle:

Frequency (circle): Constant Intermittent (comes and goes)

What makes the pain better? ____

What makes the pain worst? ____

Do you have any other symptoms in addition to pain? □ Yes □ No

□ fear	□ irritability	□ vomiting	□ itching	□ sleepiness
□ anxiety	□ loss of appetite	□ constipation	□ weakness	□ other __________
□ sleep problems	□ nausea	□ difficulty urinating	□ confusion	______________

Does the pain disturb your …

□ sleep	□ self-care	□ housework	□ concentration	□ mood
□ enjoyment of life	□ eating	□ walking	□ energy	□ relationships
□ recreation	□ yard work	□ cooking		

Are you depressed? □ Yes □ No Does your pain make you feel depressed? □ Yes □ No

Describe function before injury: **Normal** **Restricted** Please Specify: ____

What have you used to treat the pain:

____

____