LIMITLESS
PHYSICAL THERAPY SPECIALISTS

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: _____

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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 - Initial_____

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 - Initial_____

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 - Initial_____

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.

I acknowledge that my credit/debit/HSA card will be kept securely on file and authorize LIMITLESS PHYSICAL THERAPY SPECIALISTS, P.C. to process my payments at the time of service.

Authorization to Release Information - Initial_____

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.

I authorize LIMITLESS PHYSICAL THERAPY SPECIALISTS, P.C. to use my email address for appointment reminders, home exercise prescription, newsletters, and educational emails. Emails will be sent in compliance with HIPPA standards. I understand that I have the right to wave revoke this authorization at any time.

No Show/Cancellation Policy - Initial_____

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. **Failure to provide 24 hours notice for appointment cancellations/changes will result in 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 - Initial_____

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

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PHYSICAL THERAPY SPECIALISTS

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
□ injury related to lifting
□ cause unknown
□ recurrence of previous injury
□ injury related to falling
□ other: _____
□ motor vehicle accident
□ athletic/recreational injury

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	□	□
Kidney Problems	□	□	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 medical history: _____

_____

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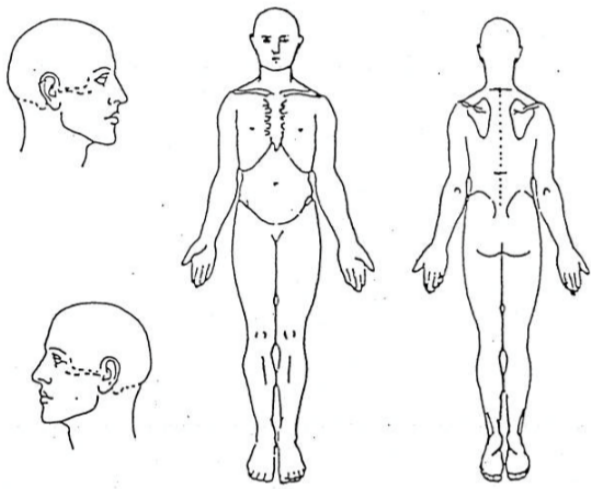
Is there anything else in your medical history that you want us to know about?: _____
_____

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 the key:



KEY

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

Check 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: _____

Since your injury, are your symptoms getting (circle): **Worse** **Better** **The same**
Frequency (circle): **Constant** **Intermittent (comes and goes)**

What makes the pain better? _____
What makes the pain worse? _____

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?: _____