FIRST SETTLEMENT PHYSICAL THERAPY

PATIENT INFORMATION

NAME: _____ DOB: _____ /_____ /_____
LAST *FIRST* *MIDDLE INITIAL*

ADDRESS: _____
STREET *CITY* *STATE* *ZIP*

SEX: ☐ M ☐ F PHONE: ( ) _____ EMAIL: _____
(Refer to 'Email Consent' section on p.4 for email use/policy)

MARITAL STATUS: ☐ M ☐ S ☐ W ☐ D SSN: _____ EMPLOYER: _____

PARENT/GUARDIAN INFORMATION (IF APPLICABLE)

PARENT/GUARDIAN NAME: _____
LAST *FIRST* *MIDDLE INITIAL*

SEX: ☐ M ☐ F DOB: _____ /_____ /_____ SSN:_____ PHONE: ( ) _____

EMPLOYER: _____ RELATIONSHIP TO PATIENT: _____

EMERGENCY CONTACT INFORMATION

In the event of an accident or a medical emergency, please list someone we may contact on your behalf:

NAME: _____ PHONE: _____ RELATIONSHIP TO PATIENT: _____

Would you like to list another person that may have access to your account information if you are unavailable? ☐ YES ☐ NO

If **YES**, NAME: _____ PHONE: _____ RELATIONSHIP TO PATIENT: _____

INSURANCE AND SUBSCRIBER INFORMATION

PRIMARY INSURANCE: _____ SECONDARY INSURANCE: _____

IS THE PATIENT THE INSURANCE POLICY HOLDER? ☐ YES ☐ NO (If **NO**, please continue below)

IF INSURANCE IS UNDER A DIFFERENT NAME THAN THE PATIENT LISTED ABOVE, PLEASE COMPLETE THE FOLLOWING:

SUBSCRIBER NAME: _____
LAST *FIRST* *MIDDLE INITIAL*

SUBSCRIBER ADDRESS: _____
STREET *CITY* *STATE* *ZIP*

SEX: ☐ M ☐ F DOB: ____ /____ /____ SSN: _____ PHONE: ( ) _____

EMPLOYER: _____ RELATIONSHIP TO PATIENT:_____

SECONDARY INSURANCE SUBSCRIBER NAME: _____
LAST *FIRST* *MIDDLE INITIAL*

SUBSCRIBER ADDRESS: _____
STREET *CITY* *STATE* *ZIP*

SEX: ☐ M ☐ F DOB: ____ /____ /____ SSN: _____ PHONE: ( ) _____

EMPLOYER: _____ RELATIONSHIP TO PATIENT:_____

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HAVE YOU RECEIVED ANY HOME HEALTH SERVICES IN THE PAST 30-60 DAYS?

☐ YES ☐ NO

If YES, please notify the front desk immediately.
Medicare will not cover physical therapy visits if you are receiving any home health services.

ACCIDENT INFORMATION (IF APPLICABLE)

Are you being treated due to an accident? ☐ YES ☐ NO

Was injury due to a motor vehicle accident? ☐ YES ☐ NO

Date of Accident: _____

Do you have legal counsel for this accident? ☐ YES ☐ NO

Was this injury work related? ☐ YES ☐ NO

WORKERS' COMPENSATION CLAIM INFORMATION (IF APPLICABLE)

Date of Injury: _____ Claim Number: _____

In what state is your Workers' Compensation claim filed? ☐ Ohio ☐ West Virginia ☐ Other: _____

Contact/MCO Name & Company: _____

Employer: _____ Phone: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR MEDICAL HISTORY

Have you fallen more than two times in the last year? ☐ YES ☐ NO

→ *If **YES** – Have you discussed this, or Vitamin-D supplementation, with your Doctor?* ☐ YES ☐ NO

Do you currently use tobacco products? ☐ YES ☐ NO

→ *If **YES** – Have you or are you seeking counseling or medical treatment to help aid in quitting?* ☐ YES ☐ NO

Have you ever been diagnosed with depression? ☐ YES ☐ NO

→ *If **YES** – Has it been treated?* ☐ YES ☐ NO

Have you been currently diagnosed with diabetes? ☐ YES ☐ NO

→ *If **YES** – Type I or Type II Diabetes?* ☐ TYPE I ☐ TYPE II

Do you have neuropathy? ☐ YES ☐ NO

→ *If **YES** – Have you had your feet screened recently?* ☐ YES ☐ NO

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Main problem or complaint that brings you here today: _____

Pain Level (Circle a number): No Pain 0 1 2 3 4 5 6 7 8 9 10 Severe Pain

PLEASE LIST ANY RECENT SURGERIES

1) _____ Date: ____ /_____ /____ 3 _____ Date: ____ /_____ /____

2) _____ Date: ____ /_____ /____ 4) _____ Date: ____ /_____ /____

Diagnostic tests for current problem? ☐ XRAY ☐ MRI ☐ BONE SCAN ☐ EMG ☐ OTHER: _____

Height: _____ ft. _____in. **Weight:** _____lbs.

Date of Injury: _____

MEDICAL HISTORY – PLEASE CHECK ALL THAT APPLY

☐ Arthritis	☐ Difficulty lying flat	☐ Loss of appetite	☐ Rash
☐ Asthma	☐ Ear pain	☐ Low blood sugar	☐ Recent weight loss/gain
☐ Cancer	☐ Heart palpitations, Murmur	☐ Lung problems	☐ Shortness of breath
☐ Change in vision	☐ Heart problems	☐ Metals	☐ Stents
☐ Chest pain	☐ High blood pressure	☐ Nausea	☐ Thyroid issues
☐ Cough	☐ Hot or Cold intolerance	☐ Pacemaker	☐ Tumors
☐ Diabetes	☐ Implants	☐ Paralysis	☐ Ulcers
☐ Dialysis	☐ Incontinence	☐ Psychiatric care	☐ Other: _____

PLEASE LIST ANY MEDICATIONS

_____

_____

_____

_____

_____

PLEASE LIST ANY ALLERGIES

_____

_____

_____

_____

_____

GOALS FOR PHYSICAL THERAPY

_____

_____

_____

FIRST SETTLEMENT PHYSICAL THERAPY

We verify financial responsibility with your insurance provider, however, please be aware that we are occasionally given incorrect information. The following information is provided as a courtesy to you, but does not constitute a binding payment agreement. It is important for you to verify your responsibility with your insurance provider. If this information is missing please check with the front office staff.

Co-pay per visit: _____ Co-insurance: _____ Deductible owed: _____

Additional information: _____ Office Mgr: _____

AUTHORIZATION AGREEMENT

Assignment of Insurance Payment, Email Consent & Use Policy, and Release of Medical Information/Consent to Treat

I hereby request that payment of authorized Medicare and Other insurance benefits be paid DIRECTLY to First Settlement Physical Therapy, Inc., for any services furnished to me by this practice. I further authorize the release to/from First Settlement Physical Therapy, Inc., any information required in the course of my examination and/or treatment. I understand that I am financially responsible for all charges and services rendered, regardless of litigation, insurance reimbursement, co-pays, collection fees or pending claims. I understand that as the parent/guardian of a minor, I will be responsible for payment. I hereby consent to treatment by First Settlement Physical Therapy, Inc. (a copy of this authorization shall serve as effective as the original). *While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.*

Insurance Cards – You must present a current insurance card at the first visit. Patients with Medicaid must present a current card every month. If you do not present your insurance card at your first visit, you will be considered a self-pay patient until we receive your insurance card and verify your benefits.

Co-pays/Standard Office Payment – Co-pay/co-insurance is due at the date of service. If you are unable to pay this amount, please speak with the front office manager.

Motor Vehicle Accident Policy – If your injury is the result of a motor vehicle accident, please inform the office manager at the initial date of service. Arrangements must be made with the billing office in regards to your account.

Work-Related Injuries – We will attempt to verify your Workers' Compensation claim with the information provided to us, however, a *claim number is not a guarantee of payment. If your claim or authorization for service is denied, for any reason, you are responsible for payment of the account balance.*

We accept the following forms of payment:

Cash • Check • Visa/MasterCard/American Express/Discover • Money Order • Care Credit

FSPT will never sell or share your email address to a third party. However, we may use your email address to send you Home Exercise Programs (HEPs) that have been discussed between you and your therapist, contact you with reminders about your upcoming therapy appointments, or notify you about products and/or services we offer. We may also check on your progress after you have been discharged and/or ask for your feedback regarding your experience at FSPT.

Please understand that unencrypted email is not a secure form of communication and there is some risk that individually identifiable health information and/or other sensitive or confidential information that may be contained in such an email may be misdirected, disclosed to, or intercepted by, unauthorized third parties. FSPT will use the minimum necessary amount of protected health information in any electronic communication with you. By signing below, you consent to receiving emails as discussed above, consent to accept the potential risks involved in receiving personal health information via email, and understand that you may withdrawal your consent at any time by speaking with the front office staff.

I, the undersigned, hereby certify that I have read, understood, and agree to the above financial policy, email consent & use policy, and have received a Notice of Privacy Practices from First Settlement Physical Therapy, Inc. In addition, I agree to authorize First Settlement Physical Therapy, Inc., to release all information necessary to secure payment of benefits and use this signature on all claim submissions.

Signature: _____ Date: _____ /_____ /_____

Print Name: _____ Relationship to patient: _____