FORM & FUNCTION

Patients Name_____ D.O.B. _____ Are you over the age of 18? YES / NO

Address: _____ City/State/Zip: _____

Home Phone Number: _____ Cell: _____ Work: _____ Male/Female

SSN: _____ Email Address: _____ **Diagnosis:** _____

Employer: _____ Occupation: _____

Emergency contact: _____ Phone: _____

Referring Doctor: _____ Phone: _____ Fax: _____

Primary Care Doctor: _____ Phone: _____ Fax: _____

Please provide insurance cards for front desk to be copied

RESPONSIBLE PARTY (IF PATIENT IS A MINOR/ INSURANCE SUBSCRIBER NOT SELF)

Name: _____ Address: _____

City/State/Zip: _____ D.O.B. _____ SSN: _____ Phone Number: _____

MEDICAL INSURANCE INFORMATION

Patient relationship to subscriber: Self Spouse Child Other

Primary Insurance: _____ ID#: _____ Group#: _____

Secondary Insurance: _____ ID#: _____ Group#: _____

IS THIS INJURY THE RESULT OF AN ACCIDENT? ___AUTO ___WORK ___SCHOOL OTHER: _____

Date of injury/Accident: _____ State Where Accident occurred: _____

Will you want us to submit any of your medical bills to the accident insurance? YES / NO

(Note: If you do choose to go through insurance relate to an accident, we do not accept third party billing. If you choose to go through your personal medical insurance, some insurance plans do not cover accident related injuries. Please inform front desk if any of these apply.)

Insurance Company: _____ File/Claim# _____

Adjustor's Name: _____ Adjustor/Accident Insurance Phone #: _____

Address: _____ City/State/Zip: _____

Attorney Involved? YES **(If yes complete below)** / NO

Attorney Name: _____ Phone # _____

Address: _____ City/State/Zip: _____

Consent to Treat and Acknowledgement of Terms

The undersigned authorizes Form & Function to complete a physical therapy evaluation and to administer treatment that is necessary and appropriate. By signing below, I attest that all information I provide is true and correct. I have read, understood, and accept policies I stated above:

PATIENT SIGNATURE: _____ DATE: _____

(PLEASE FILL BOTH SIDES OF THIS FORM)

Form & Function

Medical History Information

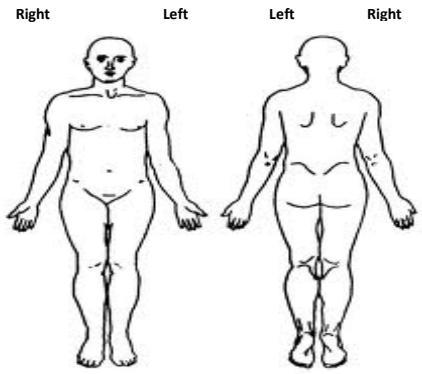
Height: _____ Weight: _____lbs.

Current Medications: _____

Check any that apply:

____High blood pressure
____Bowel/bladder problems
____Weight loss or gain
____Asthma or allergies
____Heart murmur
____Diabetes
____Night sweats
____Heartburn
____Headaches
____Metal implants
____Low blood sugar
____Shortness of breath
____Heart problems
____Frequent urination
____Loss of appetite
____Lung problems
____Abnormal heart rate
____Cancer
____Fever
____Joint pain/swelling
____History of trauma
____Frequent joint sprains
____Ulcers
____Pacemaker or ICD
____Angina
____Thyroid problems
____Neck or back pain
____Pregnant
____Chest Pain
____Osteoporosis
____History of fractures
____Seizures / epilepsy

Shade In Where You Are Having Pain



Surgery/dates:

_____

_____

Are there any other medical conditions that we must know about? _____

_____

Billing Statement

Form and Function recommends that you check your physical therapy benefits by calling the number on the back of the insurance card. Physical therapy often falls under the major medical portion of benefits, resulting in copays and deductibles that are **different** from an office or doctor visit. Any benefit quoted to you by the insurance company over the phone is not a guarantee of payment. Insurance companies can sometimes take over 4-6 weeks for payment, so patients often receive bills after their physical therapy sessions have ended. You will often receive multiple patient bills as insurance companies usually pay in small installments.

We will provide you with an **estimated** copay amount if your plan calls for a percentage or co-insurance. If you do not pay all copays at the time of service we will be balance billing you.

PATIENT SIGNATURE: _____DATE: _____
(Parent/Guardian if minor)

PLEASE SIGN BELOW FOR NOTICCE OF PRIVACY PRACTICES-ACKNOWLEDGEMENT FORM
I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES AND HAVE BEEN PROVIDED AN OPPORTUNITY TO REVIEW IT

PATIENT SIGNATURE: _____ DATE: _____