CUSTOM

Physical Therapy and Fitness

**Patient:**_____**Gender**_____

**DOB:**_____ **Age:** _____ **Phone:**_____

**Address:**_____**City:**_____ **State:** _____ **Zip:**_____

**Email:**_____**Phone/Cell**_____

**Social Security#:**_____

**If Under 18, Parent/ Guardian**_____
**Would you like to receive appointment reminders? Yes☐ No☐, If so via: Email☐ Text☐**

**Emergency Contact:**_____**Phone:**_____

**Do you have a referral/ script from your doctor? Yes☐ No☐**

**Referring MD/PA/NP:**_____**Return Date:**_____

**Practice Name:**_____**Fax:**_____

**INSURANCE INFORMATION:**

| **PRIMARY** | **SECONDARY** |
|---|---|
| **Insurance Co. Name** _____ | **Insurance Co. Name**_____ |
| **Policy Holder:**_____ | **Policy Holder**_____ |
| **Policy Holder DOB:**_____ | **Policy Holder DOB**_____ |
| **Policy Number:**_____ | **Policy number:**_____ |
| **Group Number:**_____ | **Group Number**_____ |

**WORKERS COMPENSATION CLAIMS:**

**Claim Number:**_____**Phone:**_____

**Date of Injury:**_____ **NCM/Adjuster:**_____

**MVA ACCIDENT**
**Ins Comp:**_____ **Claim #:** _____

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**Tel:**_____ **Fax:**_____

**Past Medical History:HAVE YOUR EVER EXPERIENCED ANY OF THE FOLLOWING:**

| | |
|---|---|
| ☐ Asthma | ☐ High Blood Pressure |
| ☐ Pneumonia | ☐ Osteoarthritis/Rheumatoid Arthritis |
| ☐ Cancer | ☐ Congestive Heart Failure |
| ☐ Stroke (CVA/TVA) | ☐ Visual or Hearing Impairments |
| ☐ Seizures/ Epilepsy | ☐ Depression Anxiety |
| ☐ Diabetes Type 1/2 | ☐ Neurological Disease |
| ☐ Chronic Headaches | ☐ Other: Describe below |

**List ANY recent diagnosis? (List any Surgeries, Injections, Xray)**_____

_____

_____

**Are you on any blood thinners?Yes☐ No☐ Are you allergic to LATEX?Yes☐ No☐**

**Please list all the medications you are currently taking:**_____

_____

_____

_____

**Please tell us what brings you in today?**_____

_____

_____

_____

**What makes your symptoms better?**_____

_____

_____

_____

**What makes your symptoms worse?**_____

_____

_____

**My symptoms are, Constant☐ Intermittent ☐ Chronic☐ New☐**

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**Consent for Care and Treatment**: I hereby agree and give my consent to ***Custom Physical Therapy and Fitness*** to furnish the appropriate rehabilitative care and treatment, as considered necessary and in the best interest in order to attend to the physical condition. I understand that benefits and risks to all interventions will be explained and that the patient holds the final judgement in such matters

Potential Risk: I understand that I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing condition or injury. The discomfort is usually temporary, and if it does not subside in 24 hrs, I agree to contact my physical/ occupational therapist.

Cooperation with treatment: In order for physical/occupational therapy treatments to be effective, I must come to scheduled appointments unless I notify my therapist. I understand and agree to cooperate with and perform the home exercise program provided for me. If I have difficulty with any part of my treatment program, I will communicate with my therapist.

**Authorization to Release Patient Information**: I hereby authorize Custom Physical Therapy and Fitness to release any protected health information (PHI) required in the course of the examination or treatment to the insurance company, or their affiliates, of which I provided the information

I also authorize the release of appointment information left in a voice answering machine or text message and understand the level or privacy risks associated with these forms of communication.I understand I can withdraw my consent to receiving texts or emails at any time and that I am not required to consent to receiving texts or emails as a condition of receiving treatment.

HIPAA Consents: In Compliance with HIPAA regulations, I consent to the following individuals receiving telephonic/ email information regarding the billing of my account.

_____

_____

I authorize the release of any medical records to the following physicians/ primary care provider or insurance company:

_____

_____

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**Authorization to Pay:** I hereby authorize insurance payment directly to Custom Physical Therapy and Fitness, billing department for medical services rendered. I understand that I am financially responsible for the charges not covered by my insurance. In the event of default, I promise to pay collection cost and reasonable fees as may be required to obtain collection of this account

I have read the above information and I consent to physical/occupational therapy evaluation and treatment.

_____

**Print Name**

_____ _____

**Sign** **Date**

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# RECURRING CREDIT CARD PAYMENT AUTHORIZATION

By signing this document you authorize Custom Physical Therapy and Fitness LLC., to process regularly scheduled charges to your credit card. You will be charged the amount indicated by Custom Physical Therapy and Fitness, your insurance carrier, for services rendered. A receipt for each payment will be provided to you and the charge will appear on your credit card statement. You agree that no prior-notification will be provided unless the date or amount changes, in which case you will receive an email/phone notification from us at least 5 days before the payment will be processed.

I _____ authorize Custom Physical Therapy and Fitness LLC., to charge my credit card indicated below for copays, co-insurance balances.

**BILLING INFORMATION:**

Billing Address_____ Phone: _____

City, State, Zip_____ Email: _____

**CREDIT CARD DETAILS**:(Please note this information is stored in a secure and HIPAA compliant EMR system, not to be disclosed or utilized for any other reasons other than those stated above.)

**Visa** ☐ **Mastercard** ☐ **Discover** ☐ **American Express** ☐ **HSA/FSA** ☐

Card Holder Name:_____
Account/CC #:_____
Expiration Date:_____/20_____
CVV_____ Zip Code:_____

**I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Custom Physical Therapy and Fitness LLC., in writing of any changes in my account information of termination of this authorization at least 15 days prior to the next billing date/ at my next scheduled appointment. If the above payment date falls on a weekend or holiday, I understand that the payments may be executed on the next business day. I acknowledge that the origination of the Credit Card transactions to my account must comply with the provisions of U.S. Law. I certify that Iam an authorized user of this Credit Card and will not dispute these transactions, so long as the transitions correspond to the terms indicated in this authorization form.**

_____ _____
Patient signature Date