Welcome to Angeline Physical Therapy, LLC (dba, Angeline Physical & Aquatic Therapy)

PATIENT'S INFORMATION SECTION

Patient's Last Name _____ Patient's First Name _____

Patient's Address _____ City _____ St_____ Zip _____

Patient's HOME PHONE # _____ Patient's CELL PHONE # _____

Patient's Date of Birth: _____/_____/_____ Patient's Sex: M F

Patient's Marital Status (Please Circle one)**:** *Married* *Single* *Divorced* *Widowed*

Domestic Partner *Legally Separated*

Patient's SS#: _____-_____-_____ Email Address: _____

Patient's Employment Status (Please Circle one): *Full Time* *Part Time* *Retired* *NA*

Employer's Name _____ Employer's Phone # _____

Student Status (Please Circle one): *Full Time* *Part Time* *School Name*_____ ***NA***

What is the name of the physician who prescribed your Physical Therapy? _____

Physician's Address (if known): _____ City _____ St_____ Zip _____

INSURANCE SUBSCRIBER & INSURANCE INFORMATION

PRIMARY INSURANCE

Name of Subscriber: _____ Birthdate: _____/_____/_____

Relationship to Patient: _____ Phone: (_____) _____-_____

SS#_____-_____-_____ Insurance Co: _____

Subscriber #:_____ Group #/Name: _____

SECONDARY INSURANCE

***If you have NO Secondary Coverage Initial Here (_____)

Name of Subscriber: _____ Birthdate: _____/_____/_____

Relationship to Patient: _____ Phone: (_____) _____-_____

SS#_____-_____-_____ Insurance Co: _____

Subscriber #:_____ Group #/Name: _____

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Authorization To Release Information

Besides the physician(s) and healthcare providers involved in your care, please indicate anyone with whom Angeline Physical Therapy, LLC and/or Angeline Physical & Aquatic Therapy (APT) may discuss aspects of your treatment. These aspects primarily would include your health, medical and/or billing information and/or your scheduled appointments.

1) _____ _____ _____
Name Relationship Phone #

2) _____ _____ _____
Name Relationship Phone #

3) _____ _____ _____
Name Relationship Phone #

I, _____ **DO** Authorize APT to release/discuss, my health, medical, billing, and appointment information to the above named individuals.

_____ _____
Patient's Signature (Guardian's if under 18 years of age) Date

****

I, _____ **DO NOT** Authorize APT to release/discuss, my health, medical, billing, and appointment information to anyone other than myself.

_____ _____
Patient's Signature (Guardian's if under 18 years of age) Date

****

I furthermore authorize information regarding my health, medical, billing, and appointment times to be (please initial all that you approve):

Left on my voicemail (please initial) _____

Emailed to the email I provided in the "Patient's Information Section" (please initial) _____

I would like to receive Appointment Reminders By Email? (please initial) _____

I would like to receive Appointment Reminders By Text? (please initial) _____

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FINANCIAL POLICY AND INSURANCE INFORMATION

I understand and agree that insurance claim forms will be submitted to my insurance company as a matter of convenience only, and that **I am responsible for all the charges regardless of my existing medical coverage**. I hereby give authorization for payment of insurance benefits to be made directly to APT for services rendered. In the event that my insurance company forwards payment directly to me, instead of APT, I will immediately deliver said payment to APT.

I understand and agree that I am wholly responsible and liable for payment of all charges assessed for professional services rendered and will pay any sum due, upon demand. I understand that failure to cancel in 24 business hours or show for my scheduled appointment, will result in a $25.00 fee applied to my bill. I understand and agree that if it becomes necessary for APT to utilize an outside collection agency or to commence court action, for the collection of any outstanding charges, I will be responsible for the outstanding balance (plus a $50 processing fee), and in addition, attorney fees, court costs and other expenses of litigation.

_____Date:_____ Relationship to Patient: _____

Signature of Person Responsible for Charges

(Parent or legal guardian must sign if patient is under 18 years of age)

ACKOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I understand APT reserves the right to modify the privacy practices outlined in the notice and I have received or been offered a copy of the Notice of Privacy Practices for APT.

(Please Circle One) **Received** **Offered**

Signature: _____Date:_____

(Parent or legal guardian must sign if patient is under 18 years of age)

Medical History

Name: D.O.B.

Existing or Relevant Previous Conditions

Allergies	◯Yes◯No	Dizzy Spells	◯Yes◯No	MRSA	◯Yes◯No
Anemia	◯Yes◯No	Emphysema/Bronchitis	◯Yes◯No	Multiple Sclerosis	◯Yes◯No
Anxiety	◯Yes◯No	Fibromyalgia	◯Yes◯No	Muscular Disease	◯Yes◯No
Arthritis	◯Yes◯No	Fractures	◯Yes◯No	Osteoporosis	◯Yes◯No
Asthma	◯Yes◯No	Gallbladder Problems	◯Yes◯No	Parkinsons	◯Yes◯No
Autoimmune Disorder	◯Yes◯No	Headaches	◯Yes◯No	Rheumatoid Arthritis	◯Yes◯No
Cancer	◯Yes◯No	Hearing Impairment	◯Yes◯No	Seizures	◯Yes◯No
Cardiac Conditions	◯Yes◯No	Hepatitis	◯Yes◯No	Smoking	◯Yes◯No
Cardiac Pacemaker	◯Yes◯No	High Cholesterol	◯Yes◯No	Speech Problems	◯Yes◯No
Chemical Dependency	◯Yes◯No	High/Low blood pressure	◯Yes◯No	Strokes	◯Yes◯No
Circulation Problems	◯Yes◯No	HIV/AIDS	◯Yes◯No	Thyroid Disease	◯Yes◯No
Currently Pregnant	◯Yes◯No	Incontinence	◯Yes◯No	Tuberculosis	◯Yes◯No
Depression	◯Yes◯No	Kidney Problems	◯Yes◯No	Vision Problems	◯Yes◯No
Diabetes	◯Yes◯No	Metal Implants	◯Yes◯No		

Describe any other conditions

If "Yes" to Any of the above, please explain and give approximate dates/Describe any other Conditions

Fall History

Injury as a result of a fall in the past year? ◯Yes◯No

Two or more falls in the last year? ◯Yes◯No

Patient at risk for falls? ◯Yes◯No

Hand Dominance ◯Right◯Left

Surgical History

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

Current Medications

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

- **Currently not taking any medications**

Patient Instructions

(Please Initial the line next to each number)

_____1**)** Our physical therapists are **Jeff Angeline MEd, PT, AT and Dr. Scott Asher, DPT, PT.** Our Physical Therapy Assistant is **Paige Huntsberger, PTA**. If you have any questions regarding your physical therapy plan, please feel free to ask your therapist at any time.

_____2) Please be aware that there will be students/aides that will assist you in your program as well. This is a great environment for a "hands on" learning experience that we can provide them.

_____3) Please be on time for your scheduled appointments. Please call in advance if you are running late for your scheduled appointment. If you arrive late without calling, your treatment time may be lessened and in some cases, we may not be able to work with you on that day.

_____4) Failure to cancel within 24 business day hours or a no show for your schedule appointment will result in $25.00 fee applied to your bill.

_____5) **VERY IMPORTANT !!!** We like to stay in contact with your referring doctor. When you are scheduling your PT appointments, please alert the scheduler in a timely enough manner of any upcoming follow-up appointments with your physician. That way we can properly schedule time to reevaluate you and provide him/her a PT progress report.

_____6) When you see your doctor, please get a new, updated prescription to continue physical therapy. The doctor can either sign the progress note we send or write up a new prescription.

_____7) If you are scheduling two times per week, we ask you not to schedule 2 days in a row if possible. If you are scheduling 3 times a week, you are allowed to schedule 2 of the days in a row but not 3 days in a row.

_____8) **Insurance**: Your insurance benefits are a **contract between you and your insurance company**. It is your responsibility to be aware of your benefits, so we encourage you to call them and verify your coverage. As a courtesy, we will also call them after your initial evaluation and review them with you. However, we CAN NOT be responsible for any information misquoted to us by your insurance company's representatives.

HOURS OF OPERATION

Monday	Tuesday	Wednesday	Thursday	Friday
7:00-1:00	8:00-12:00	8:00- 12:00	9:00-1:00	7:00-1:00
2:00-7:00	1:00-5:00	Closed at	2:00-7:00	1:00-5:00
Lunch 1-2:00	Lunch 12-1:00	12 Noon	Lunch 1-2:00	Lunch 12-1:00

****Please like us on Facebook under Angeline Physical and Aquatic Therapy. Stories about your experiences at our facility are always welcome.**