Name:_____ **Referring Physician:**_____

Family Physician: _____ **Date of Injury/Onset:**_____

Date of 1st Doctor Visit for this Injury/Episode:_____
Last Date Worked Due to this Injury: _____

Height_____ **Weight**_____

Have you had Home Health Care? YES NO **Last Date of Home Health Care:**_____

Is an Attorney Involved in this Case? YES NO

Have you had Surgery for this injury? YES NO
Type of Surgery:_____ **Date of Surgery:**_____

Are You Currently Taking Any Prescription or Non-Prescription Medications? YES NO
Anti-inflammatories ___ Muscle Relaxers ___ Pain Medication ____
List Medications: _____

Are You Allergic to any Medications? YES NO **List Medications:** _____

Have you had any of the following Medical or Rehabilitative Services for this Injury/Episode?

	YES	NO		YES	NO
Chiropractor	__	__	CT Scan	__	__
EMG/NCV	__	__	General Practitioner	__	__
Massage Therapy	__	__	MRI	__	__
Myelogram	__	__	Neurologist	__	__
Occupational Therapy	__	__	Orthopedist	__	__
Physical Therapy	__	__	Podiatrist	__	__
Emergency Room Care	__	__	X-Rays	__	__

Other:_____

If any X-Rays, MRIs or CT Scans were done for this episode, please indicate where:_____

Have you ever had ANY of the following?

	YES	NO		YES	NO
Asthma, Bronchitis, or Emphysema	__	__	Severe or Frequent Headaches	__	__
Shortness of Breath/Chest Pain	__	__	Vision or Hearing Difficulties	__	__
Coronary Heart Disease or Angina	__	__	Numbness or Tingling	__	__
Do you have a Pacemaker?	__	__	Dizziness or Fainting	__	__
High Blood Pressure	__	__	Bowel or Bladder Problems	__	__
Heart Attack or Surgery	__	__	Weakness	__	__
Stroke/TIA	__	__	Weight Loss/Energy Loss	__	__
Congestive Heart Disease	__	__	Hernia	__	__
Blood Clot/Emboli	__	__	Varicose Veins	__	__
Epilepsy/Seizures	__	__	Allergies	__	__
Thyroid Disease or Goiter	__	__	Any Pins or Metal Implants	__	__
Anemia	__	__	Joint Replacement Surgery	__	__
Infectious Diseases	__	__	Neck Injury/Surgery	__	__
Diabetes	__	__	Shoulder Injury/Surgery	__	__
Cancer or Chemotherapy/Radiation	__	__	Elbow/Hand Injury/Surgery	__	__
Arthritis	__	__	Back Injury/Surgery	__	__

Osteoporosis	___	___	Knee Injury/Surgery	___	___
Gout	___	___	Leg/Ankle/Foot Injury/Surgery	___	___
Sleeping Problems/Difficulties	___	___	Are You Pregnant?	___	___
Emotional/Psychological Problems	___	___	Do You use Tobacco?	___	___

List any other information that would assist us in your care:

_____

Are you aware of your diagnosis and prognosis as explained by your doctor? YES NO

Based on your awareness, What are your rehabilitation expectations/goals while in this program?

_____

Patient/Guardian Signature: _____

Date: _____

CONSENT FOR TREATMENT

I, the undersigned, do hereby agree and give my consent for Riptide Physical Therapy to furnish medical care and treatment to _____as considered necessary and proper in diagnosing and/or treating of
(Print Patient Name)
his/her/my condition.

Patient/Guardian/Responsible Party_____Date _____

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I hereby assign all medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third party payers, to ***Riptide Physical Therapy.*** A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records, to secure payment.

Patient/Guardian/Responsible Party_____ Date _____

HIPAA DESIGNATION

I (print name)_____, DOB _____, designate the following person(s) to be
(Print Patient Name)
able to speak with the staff at Riptide Physical Therapy on my behalf about my medical condition or the status of my account. I release Riptide Physical Therapy and its staff from any claim of confidentiality in connection with the release of this information.

Name of Designated Person:_____

Relationship:_____Phone #:_____

Name of Designated Person_____

Relationship:_____Phone #:_____

__ I do NOT wish to designate anyone at this time.

Patient Signature_____ Date_____

RIPTIDE
PHYSICAL THERAPY

Office/Financial Policy

As a courtesy we check your insurance benefits and out of pocket expenses. We try to make the billing process go as smoothly as possible for our patients. We also recommend that you contact your insurance carrier and check your outpatient physical therapy benefits.

Patient responsibility is determined as per the explanation of benefits, and we as a contracted provider are legally obligated to collect all amounts stipulated by the insurance company to be the patient's financial obligation. We are happy to answer any questions or concerns you have.

Copays, coinsurances, and deductibles are to be paid at each visit or at the beginning of the week for all scheduled appointments. We accept Visa, Discover, Mastercard, cash, and checks. We will work with you with payment options if needed.

It is important and beneficial to be consistent with your physical therapy. However, if you need to cancel or reschedule an appointment, please give us a call 24 hours prior and we will be happy to help you. Two cancellations, without a 24 hour notice will be charged a $25 fee. One no-show visit will result in a $25 charge.

With my signature I fully understand and agree to comply with all information set forth in this document.

_____ _____

Patient/Guardian/Responsible Party Date

_____ _____

Facility Representative/Witness Date