Elevate Physical Therapy

Patient Information

****Please present your insurance card(s) for copying.****

Patient Name:	Date of Birth:	Age:	Sex: M F
Social Security Number: X X X – X X –	Employment Status: Emp Unemp Retired Student Home	Marital Status: Single Married Other	
Address:	City, State, Zip		
Home Phone: OK to leave message? Yes No	Cell Phone:	Email:	Employer:
Referring MD:	Primary Care MD:		
Financial Party: (if other than patient)	Relationship:	Social Security Number:	Date of Birth:
Home Phone:	Work Phone:	Employer:	
Emergency Contact:	Relationship:	Home Phone:	
Address:	Work Phone:		

Cancellation Policy and Consent to Treat

We at Elevate Physical Therapy want to provide the best possible care for our patients and attending your scheduled appointments is a necessary part of the treatment process. If there is not notice of cancellation 24 hours before the scheduled appointment, **a $20 no-show fee will be billed directly to the patient for each cancellation made without proper notice.**

By signing below, you acknowledge that you have read, understood and agree to abide by our cancellation policy as described. You also acknowledge the above patient information is correct to the best of your knowledge.

I grant permission for the staff of Elevate Physical Therapy, to perform the procedures as prescribed by my physician including a physical therapy evaluation. During this evaluation, the nature of the procedures that will be performed as well as the potential risks of care will be explained to me.

If I become ill while undergoing treatment, I give permission to the staff to administer treatments which they consider necessary to my well-being. **My signature below indicates that I understand and give consent to be treated as explained above.**

Patient Signature:	Guardian's Signature: (If patient is <18 years old)	Date:

Elevate Fitness and Rehab also offers the following wellness services, please let us know if you are interested in:

Chiropractic ☐ **Massage** ☐ **Personal Training/Weightloss** ☐ **Triathlon Coaching** ☐

ELEVATE PHYSICAL THERAPY

Patient Medical History Form – For Clinic Use ONLY

Name:	Age:	Current Concern/Problem:	Date of Onset:

I. Have you ever been diagnosed with any of the following conditions? FILL IN THE APPROPRIATE CIRCLES.

1. Cancer:	Yes	Type(s), include date of diagnosis:
	O	

2. Infection:	Yes	No	3. Cardiovascular:	Yes	No
Chronic Urinary Tract/Kidney Infection	O	O	Heart Disease:	O	O
Pneumonia	O	O	Deep Venous Thrombosis (DVT):	O	O
Bone/Joint Infection	O	O	Arterial Blockage of the Legs	O	O
Viral Conditions:	O	O	High Blood Pressure:	O	O
Other Infection: (Please List)	O	O	Stroke/TIA	O	O
1.			Other:		

4. General Medical Conditions:	Yes	No	4. General Medical Conditions:	Yes	No
Rheumatologic Disorders:	O	O	Osteoarthritis: (Wear-and-Tear Arthritis)	O	O
Lung Disorders:	O	O	Osteoporosis/Osteopenia:	O	O
Liver/Kidney Conditions:	O	O	Dizziness or falls:	O	O
Gastrointestinal Disorders:	O	O	Depression:	O	O
Neurological Disorders:	O	O	Bowel/Bladder Incontinence:	O	O
Anemia/Blood Disorders:	O	O	Headaches: (more than 1 per week)	O	O
Thyroid Conditions:	O	O	Vision or hearing difficulty	O	O
Gout:	O	O	Immunologic/Allergy Conditions:	O	O
Diabetes:	O	O	Genitourinary/Gynecologic Conditions	O	O
Dermatologic Conditions:	O	O	Other conditions:		

II. Please List All Medications Including Frequency and Dosage: (both over-the-counter and Prescribed)

	Frequency	Dosage		Frequency	Dosage
1.			7.		
2.			8.		
3.			9.		
4.			10.		
5.			11.		
6.			12.		

III. Surgeries and/or Hospitalizations:		IV. Other Current Conditions:	Yes	
1.	Date:	1. Recent, unplanned weight loss?	O	O
2.	Date:	2. Unexplained night pain?	O	O
3.	Date:	3. Fevers or night sweats?	O	O
4.	Date:	4. Nausea/Vomiting?	O	O
5.	Date:	5. Unexplained weakness or fatigue?	O	O

V. Health-Related Habits

Smoking	Yes	No		Yes	No
If yes, < 1 pack/day?	O	O	Do you have a Pacemaker?	O	O
If yes, > 1 pack /day?	O	O	Are you Latex Sensitive?	O	O
Ice Sensitive?	O	O	Heat Sensitive?	O	O
Previous experience with physical therapy?	O	O	How many falls have you had in the last year? __________	Are you currently pregnant?_____	

I affirm that the above information is accurate and true.

Patient Signature__________________________ Date_______________ Therapist Review (Initials) ________

**Adapted from: Boissonnault WG, Badke MB. Collecting health history information: The accuracy of a patient self administered Questionnaire in an orthopedic outpatient setting. *Phys Ther*. 2005; 85(6):531-543.

Elevate Physical Therapy

FINANCIAL POLICY

In order to provide the best possible care and most effective treatments, this is the financial policy of Elevate Fitness and Rehab.
This is an agreement between Elevate Physical Therapy (EPT) and the Patient/Responsible Party signed on this form. **By executing this agreement, you are responsible for all medical bills and other charges that result from services rendered by EPT.**
Please remember that insurance is considered a method of reimbursing the patient for fees paid to the provider and is not a substitute for payment. Regardless of insurance coverage you are responsible for all balances incurred. Some insurance companies may pay fixed allowances for certain procedures, sometimes referring to these as "Reasonable and Customary Fees." We do not accept this as payment in full, unless otherwise restricted by law or contract agreement we may have with your insurance carrier(s). Many insurance companies pay only a percentage of the charge, leaving it your responsibility to pay any deductible amount, co-insurance amount, co-pays (due at each visit) and any other balance not covered by your insurance carrier(s). As a courtesy, our office may inform you of the benefits we were quoted by your insurance carrier(s). However, this is not a guarantee of your actual benefit plan or payment. If you have any further questions, please contact your insurance carrier(s).

ASSIGNMENT OF BENEFITS: I hereby assign all medical/physical-occupational therapy benefits, to which I am entitled, Medicare, private insurance and other health plans to: Elevate Sports Medicine, EPT. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize EPT to release all information necessary to secure the payment, via fax transmittal or hard copy. Medical records will be accessible to all physical therapists of EPT.

INJURIES AT WORK: In the event it is determined by your industrial/Workman's Compensation insurance that the illness/injury is not a result of a compensated Workman's Compensation case, you will be responsible to pay usual and customary fees for services rendered. If you do not have your information at this time, please get it to us within 48 hours.

AUTO ACCIDENTS: Auto insurance claims will be billed to YOUR auto carrier, not to any other parties' auto carrier due to Utah's No Fault Law. If your auto PIP exhausts, which in many cases is true, as you may have already been to the emergency room, had surgery, etc, we will bill your health insurance that you have provided. If you wish to not have your health insurance billed, you will be responsible for all charges. If you do not have your information at this time, please get it to us within 24 hours.

PERSONAL INJURY: If you are dealing with a lawsuit or claim, we require verification from your attorney, as well as a lien agreement that we may keep on file and a monthly payment plan. Please remember even if you have an attorney you are ultimately responsible for your bill and need to update our office on the status of your case frequently.

PAST DUE ACCOUNTS: An account becomes past due 30 days after it becomes patient responsibility. Your balance will be communicated by statement every month. If your account becomes past due, we will take necessary steps in contacting you to collect this debt. If these attempts do not generate a response from you, your account could be subject to the following fees: Finance Charges (currently 3%), In House Collection Fees, Collection Agency fees and any Attorney fees.

RETURNED CHECKS: There is a fee (currently $20) for any checks returned by the bank.

MISSED APPOINTMENT FEE: The second time a patient does not show up on time for an appointment or cancels with less than 24 hours notice, a $20 fee will be charged. This fee must be paid before a new appointment is scheduled.

SELF PAY ACCOUNTS: If you do not have health insurance we do offer self pay plans. Self Pay payments are due at the time of service. Please speak to our Clinical Director for more information. If you are unable to provide us with your health insurance, worker's compensation insurance or personal injury insurance within 48 hours of your first visit you may be turned over to a self pay account status. Even if you provide us with your insurance information after the initial 48 hour period we reserve the right to refuse to bill your insurance.

MONTHLY STATEMENT: If you have a balance on your account, we will send you a monthly statement. Unless other arrangements are approved by us in writing, the balance on your statement is due and payable on or before the due date specified on the statement and is past due if not paid on or before that date. We do charge interest (3%) on all past due accounts; interest will begin accruing once the account becomes 90 days past due.

In signing this agreement, I consent to a therapy evaluation and subsequent treatment provided and directly supervised by a licensed physical and/or physical therapy assistant employed by Elevate Sports Medicine as well as agree to all of the terms and conditions contained herein and the agreement will be in full effect.

Patient Name: ______________________ Signature: ______________________

Responsible Party:
(If patient is a minor) ______________________ Date: ______________________