Comprehensive Physical Therapy Associates

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www.ComprehensivePhysicalTherapy.net

General Information

Last Name ________________________________ First Name ____________________________
Date of Birth (MM/DD/YYYY)_____/______/_______ Current Age ______________
Address ____
City ______________________________ State_____________ Zip Code _______________________
Phone: Home _______ - _______ -__________ Office _______ - _______ -_________ ext. ________
Mobile _______ - _______ -__________ E-mail ___________________________________

Referral/ Diagnosis

Primary Care Physician ____
Referring Physician ____
Diagnosis ____
Describe your symptoms/condition in your own words ____
____
____

Current Health/ Past Medical History

Do you currently or have you ever suffered from any of the following:

Y☐ N☐ **Diabetes** Y☐ N☐ **Heart condition** *describe*: ________________________
Y☐ N☐ **High blood pressure** Y☐ N☐ **Lung condition** *describe*: ________________________
Y☐ N☐ **Dizziness** Y☐ N☐ **Cancer** *where & when*: ___________________________

Please list any other medical conditions that we should know about:_____________________________
____

Women, are you currently pregnant? Y☐ N☐

If you currently take any medications, please list their names and what they are for**:**

Name: _______________________ For: ____
Name: _______________________ For: ____
Name: _______________________ For: ____
Name: _______________________ For: ____

If you have ever had surgery, please list type of surgery and date**:**

Type of Surgery: ________________________________ Date: __________________________
Type of Surgery: ________________________________ Date: __________________________
Type of Surgery: ________________________________ Date: __________________________

Have you had physical therapy for *this* condition before? If so, list when, where, and the number of treatments you received ____
____

Note: If you have had any physical therapy this year, it is important to tell us how many visits you have had to date. This will determine how many visits you will have available based on your physical therapy benefit limitation.

PLEASE COMPLETE OTHER SIDE...

Insurance Information/ Authorization to Pay

Primary Insurance ________________________ Name of Insured __________________________

Is the insured □ Yourself, or □ Other? *If Other, please specify relationship to you*: __________________

Social Security/Medicare #____

Secondary Insurance ____

Person to notify in case of emergency____

Phone ______ - ______ -__________ Relationship to you ________________________________

I request that payments be made on my behalf to Comprehensive Physical Therapy for services furnished to me by the provider. I authorize the release of any information needed to process my claims for payment.

Signature ______________________________ Date: (MM/DD/YYYY)______/______/_______

Notice of Patient Information Practices

I, the undersigned, hereby acknowledge that Comprehensive Physical Therapy Associates, P.C. has provided me with the HIPPA form regarding the uses and disclosures of my health information and individual rights as a patient.

Signature ______________________________ Date: (MM/DD/YYYY)_____/______/_______

Notice of Cancellation Policy

Cancellations MUST be made AT LEAST 24 HOURS prior to your scheduled appointment. A $40 fee will be charged for no shows or late cancellations. Please note that this fee is not reimbursed by your insuranc

I, the undersigned, hereby state that I am aware of the 24-hour cancellation policy.

Signature ______________________________