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 _____
How did you hear about us? _____

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 _____