Patient Name _____SS # _____-_____-_____
Date of Birth _____/ _____/_____ Age ___ Sex □M□F Marital Status _____
Mailing Address_____
City _____State _____Zip_____
Phone Home (_____) _____ Cell (_____) _____
E-Mail needed for insurance purposes _____
Employed □ Yes □No Employer: _____Phone_____
Emergency Contact _____Phone (_____) _____Relationship_____
Referring Physician _____ Primary Care Physician_____
How did you hear about us? _____
Is this injury due to a motor vehicle accident or work-related injury? □ Yes □ No

Thank You for choosing TrueRehab Physical Therapy as your health care provider. We are committed to your treatment being successful. All patients must complete our patient information forms before seeing a therapist.

Privacy Practices - Acknowledgement

We at TrueRehab Physical Therapy keep a record of the health care services we provide you. We will not disclose your record to others unless you direct us to do so or unless a legal request authorizes or compels us to do so. We will provide copies of your records to your insurance company as necessary to receive payment for our services and to your referring provider.
If you would like a copy of your records, we would be happy to provide them to you but ask you give us a few days notice.
By Initialing, I acknowledge receipt of the Notice of privacy practices. **Initials** _____

Patient Rights

I am aware as a patient I have rights, they are posted on the wall in TrueRehab's waiting room. I am also aware that if I want a copy, I can request it from the front office.
By Initialing, I acknowledge I have been informed about my patient rights. **Initials** _____

Patient Consent for Assessment and Treatment

Physical therapy treatment techniques may include, but are not limited to: manual techniques, spinal manipulation, electrotherapeutic modalities, therapeutic exercises, hot/cold modalities, manual or mechanical traction, ultrasound, and soft tissue mobilization. These may be recommended during your program. It is the policy of TrueRehab to ensure that the benefits, side effects, and potential complication of each cosen modality above are explained to you by your therapist. Throughout the program, should you have concerns or questions about any recommended treatment, you should let your therapist know so rationale for treatment and/or adjustments can be made. It is your responsibility to participate in all aspects of the program as it is imperative to its success.
I understand and agree with the above policy. I give consent for TrueRehab to provide me with an assessment and treatment for services. I understand that I can withdraw my consent at any time.
By Initialing, I acknowledge I have been informed about patient consent. **Initials** _____

Financial Policy

We will bill your insurance, however if you fail to bring your insurance information with you to your first appointment, payment will be required at the time of service. All co-pays are due at the time of service. We do follow up on any unpaid claims sent to primary insurance companies, but are not able to follow up on unpaid claims sent to a secondary insurance; that would be patient responsibility. Payment in full of any balance billed to you by our facility is required within 30 days of receipt of statement.
By Initialing, I acknowledge I have been informed about financial policy. **Initials** _____

_____ _____
Signature of Patient *or* Legal Guardian (If applicable) **Date**

Name _____ **DOB** _____

Height _____ **Weight** _____

Please briefly describe the reason for your visit today

_____

_____

Date of Injury _____ Surgery date _____or N/A_____

Allergies _____

Please check any of the following medical conditions that may be part of your current or past medical history

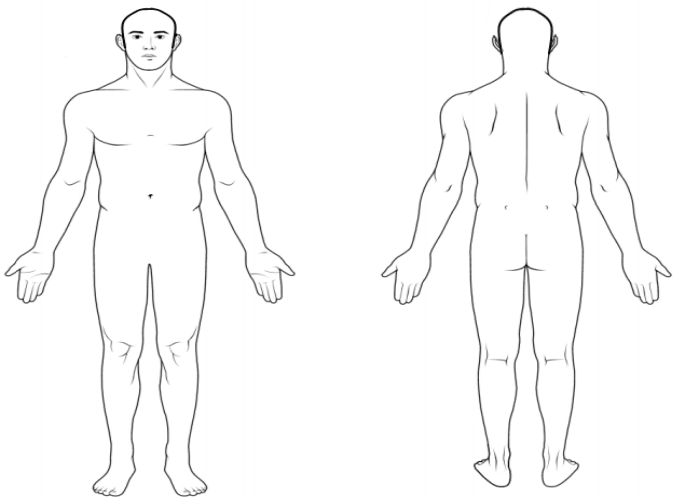
Cancer _____ High Blood Pressure _____ Heart Disease _____ Stroke _____ Diabetes _____

Osteoarthritis _____ Numbness _____ Extremity Pain _____ Headaches _____ Pregnancy _____

Any other medical condition or situation we need to be aware of _____

On a scale of 0-10 with 0 being no pain and 10 being the most severe pain, please rate your pain _____

Please indicate on the body diagram where your symptoms are located



Please list all your medications, including all prescriptions, over the counter medications, herbals, vitamins, minerals, dietary supplements, and the dosage, frequency and administration method for each medication.

Medication	**Dosage**	**Frequency**	**Method of Administration**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Patient _____Date_____ Therapist_____Date_____

Patient _____Date_____ Therapist_____Date_____

Physical Therapy Attendance Policy

TrueRehab Physical Therapy strives to provide each patient with the highest quality of care while attempting to accommodate your schedule for your convenience. We provide reserved time slots for each patient in order to minimize our waiting and assure continuity of your treatment. Your consistent attendance of the planned treatment regimen is paramount to your full recovery.

While we are sensitive to the fact that an emergency may occur in a rare instance, cancellations, especially last minute ones, along with patient no-shows, decrease our ability to accommodate the scheduling needs of the other patients.

Cancellation Policy If you need to cancel a Physical Therapy appointment, please call us ASAP (4 hours notice) so we have the opportunity to offer your appointment to another patient. If you cancel more than twice without 4 hour notice you may be charged a $20.00 cancellation fee.

No Show Policy Failure to show up for an appointment ("NO SHOW") without notifying us will result in the cancellation of all remaining scheduled appointments. You will have to contct us to get put back on the schedule. If you "NO SHOW' more than once you will be charged a $30.00 "NO SHOW" fee that must be paid before continuing therapy.

All cancellations and no-shows will be documented in your medical record and appropriately reported to your physician and insurance/third party payor.

We believe that this policy is necessary for the benefit of all our patients, so that we may continue to provide high quality treatment and service to everyone. All the staff at **TrueRehab** appreciates your cooperation with this policy.

_____ _____

Patient Acknowledgement/Signature Date