PROGRESSION
PHYSICAL THERAPY

DEMOGRAPHICS

Name (First and Last): _____

Address:_____ (Apt/Suite):_____

(City):_____ (State):_____ (Zip Code):_____

Date of Birth:_____/_____/_____ Age:_____ Gender: Male / Female
(circle one)

Phone Number: (_____) - _____ - _____

Email Address:_____

Appointment reminders can be sent via: ❑ Text ❑ Phone Call ❑ Email (default)

Occupation and Employer: _____
Are you currently working? Yes / No Full-time / Part-time / Other: _____
(circle one) *(circle one)*

Emergency Contact (Name and Relationship): _____

Emergency Contact Phone Number: (_____) - _____ - _____

Have you received physical therapy before? Yes / No
(circle one)

If YES, where?: _____

For what condition?:_____

When?:_____/_____/_____ through _____/_____/_____

REFERRAL INFORMATION

How did you hear about PROGRESSION PHYSICAL THERAPY?
❑ I was a previous patient/client ❑ My doctor ❑ Google ❑ Instagram ❑ Facebook
❑ Word of Mouth ❑ Other:_____

Referring Physician:_____
Referring Physician Office Name:_____
Referring Physician Phone Number: (_____) - _____ - _____

INSURANCE INFORMATION

Primary Insurance Provider:_____

Member ID #:_____

Policy Holder (First Name and Last Name):_____

Policy Holder Date of Birth: _____/_____/_____

Policy Holder Relationship to Patient: _____

(If applicable)
Secondary Insurance Provider:_____

Member ID #:_____

Policy Holder (First Name and Last Name):_____

Policy Holder Date of Birth: _____/_____/_____

Policy Holder Relationship to Patient: _____

MEDICAL INTAKE

Name (First and Last): _____

Height: ____ ft ____ in Weight: _____lbs Gender: Male / Female
(circle one)

Date of Birth: _____

Date of Surgery (if applicable): _____ Type: _____

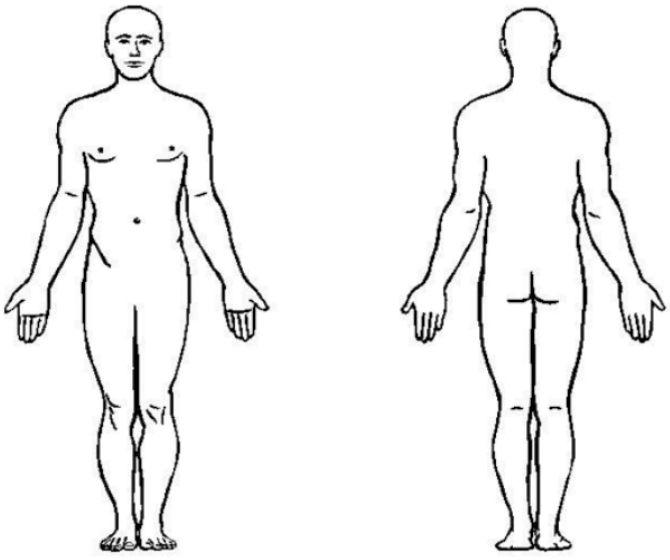
Date of Injury Onset: _____/_____/_____

Have you had these symptoms before? ☐Yes ☐No

How did this happen?
☐Athletic/Recreational Injury
☐Motor Vehicle Accident
☐Injury related to a Fall
☐Other: _____

Describe the pain:
☐Sharp ☐Shooting ☐Achy/Dull ☐ Burning
☐Numbness/Tingling ☐Other:_____

Where do you feel your symptoms?



On a scale of 0-10 [10=worst pain], what is your pain level *currently*? _____

- At its *worst*? _____
- At its *best*? _____

What activities/positions make it better? _____

What activities/positions make it worse? _____

Have you undergone any imaging procedures pertinent to your symptoms (*x-ray, MRI*)? _____

Past Medical History:

Do you have or had any of the following?

- ☐ Allergies: _____
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Heart Attack/Stroke
- ☐ Arthritis
- ☐ Artificial Joints: _____
- ☐ Pacemaker
- ☐ Cancer: _____
- ☐ Dizziness/Fainting
- ☐ History of smoking
- ☐ Currently Pregnant: _____
- ☐ Autoimmune Disease: _____
- ☐ Anxiety
- ☐ Chest Pain/Angina
- ☐ Heart Disease
- ☐ Palpitations
- ☐ Asthma
- ☐ Chronic Headaches
- ☐ Osteoporosis
- ☐ Hernia
- ☐ Shortness of Breath
- ☐ Bowel/Bladder Problems
- ☐ Seizures
- ☐ Past Surgery: _____

Is there any other information regarding your past medical history we should know about? _____

_____

Current Medications (Name, Dose (mg), Times/Day):

_____

_____

_____

What is your goal out of Physical Therapy? _____

Authorized Signature ("Patient"):_____ **Date**:_____

POLICIES AND AUTHORIZATIONS

Please **initial** next to each section to confirm that you've read, understood and agree to all of the statements below. Authorization may be revoked in writing at any time.

AUTHORIZATION FOR RELEASE OF INFORMATION

_____ I agree that Progression Physical Therapy may provide information from any part of my medical records to those involved in my medical care via phone, email or fax.

_____ I agree that Progression Physical Therapy may discuss my medical information with other members of my care team (*sports coach, primary care physician, etc.)*

INFORMED CONSENT FOR TREATMENT & ASSIGNMENT OF BENEFITS

_____ I understand that the term "informed consent" means the potential risks, benefits, and alternatives of physical therapy will be explained to me. The therapist provides a wide range of services and I understand that I will receive information at the initial consultation regarding the treatment and options available for my condition.

_____ I hereby authorize my insurance benefits to be paid directly to Progression Physical Therapy. I understand that I am financially responsible for non-covered services by my insurance company. I acknowledge that if Progression Physical Therapy does not contract with my insurance provider, I will be responsible for the difference between what is charged and what my insurance pays.

CONSENT TO RELEASE OF INFORMATION TO EMAIL AND VOICEMAIL

_____ I agree that voicemail and/or e-mail messages can be left on the phone number and/or email-address provided regarding appointments, billing or medical concerns.

CANCELLATION & NO-SHOW POLICY

_____ As a courtesy to other Progression Physical Therapy clients and staff, I will provide a minimum **24-hour** notice to modify an appointment.

_____ I understand that failure to provide a 24-hour notice may result in a $45 fee.

_____ I understand that (3) missed appointments may result in **discharge** from Progression Physical Therapy.

NOTICE OF PRIVACY PRACTICES

_____ I acknowledge that I have received a copy of the Progression Physical Therapy Notice of Privacy Practices located at the front desk and available on www.progressionpt.com.

MEDIA RELEASE CONSENT (Yes or No)

❑ YES, I grant Progression Physical Therapy permission to record my likeness and voice by video, audio, photographic or any other medium (social media, print, online) for promotional and/or educational purposes.

❑ NO, I **DO NOT** grant Progression Physical Therapy permission to record my likeness and voice by video, audio, photographic or any other medium (social media, print, online) for promotional and/or educational purposes.

Authorized Signature ("Patient"):_____**Date**:_____

PAYMENT POLICY FORM

As a courtesy to you, we will bill your primary insurance. We assume payment of insurance benefits is not forthcoming on charges older than thirty (30) days. Charges outstanding for more than thirty (30) days will be due in full from you regardless of the type of insurance involved including worker's comp. If self-pay, please pay the full balance at the time of service.

Please be advised that Progression Physical Therapy is not a credit grantor, and therefore, failure to maintain these arrangements may result in placement of your account with a collection agency or attorney for collection. In the event that your account becomes delinquent and there is a default of payment, you will be held responsible for the principal amount owed as well as all reasonable costs associated with the collection of this debt. Interest may be charged at a rate of 1.5% per month for unpaid balances over 30 days old.

Our policy is to keep a debit or credit card on file at your first visit. We reserve the right to charge your debit or credit card in the case of a NO SHOW or CANCELLATION without appropriate 24 hour notice. We reserve the right to use your debit or credit card for the full amount of your bill if payment is greater than thirty (30) days past due. Our merchant servicer charges you a 2.91% fee on all credit card transactions. **There are no fees on CASH and CHECKS**.

Checks made payable to: Progression Physical Therapy

PLEASE BE FAMILIAR WITH YOUR PHYSICAL THERAPY INSURANCE BENEFITS.

Authorized Signature ("Patient"):_____**Date**:_____