

# Parker Physical Therapy

7615 Colony Road, Suite 110

Charlotte, NC 28226

Phone: 704-364-6793 Fax: 704-364-3171

## Patient Information:

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Address: \_\_\_\_\_

Address 2 \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ SSN \_\_\_\_\_ Gender \_\_\_\_\_

Single  Married  Divorced  Widowed

Email Address \_\_\_\_\_

## Emergency Contact:

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_

## Employer:

Name \_\_\_\_\_ Phone \_\_\_\_\_ Occupation \_\_\_\_\_

## Problem Section:

Problem Description \_\_\_\_\_ Date of Injury \_\_\_\_\_ Last MD Visit \_\_\_\_\_

Have you had any falls in the past year \_\_\_\_\_

Referred by \_\_\_\_\_ Primary Care Provider \_\_\_\_\_

Motor Vehicle Accident Y / N Workers Comp Accident Y/N That occurred in what state?

## Primary Insurance: *only complete this section if you do NOT have your insurance card present.*

Insurance \_\_\_\_\_ ID # \_\_\_\_\_ Group # \_\_\_\_\_

Primary Subscriber: Name \_\_\_\_\_ Relationship \_\_\_\_\_ Date of Birth \_\_\_\_\_

## Secondary Insurance: *only complete this section if you do NOT have your insurance card present.*

Insurance \_\_\_\_\_ ID # \_\_\_\_\_ Group # \_\_\_\_\_

Primary Subscriber: Name \_\_\_\_\_ Relationship \_\_\_\_\_ Date of Birth \_\_\_\_\_

**I authorize the release of any medical or other information necessary to process this claim I authorize payment of medical benefits to Parker Physical Therapy services provided to patient.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Parent or Guardian signature required if under 18*

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Area of injury/symptoms: \_\_\_\_\_

How did your injury begin? \_\_\_\_\_

Have you had similar complaints before? \_\_\_\_\_ If yes, did you receive treatment? \_\_\_\_\_

What type of treatment and by whom? \_\_\_\_\_ Did it help? \_\_\_\_\_ Yes \_\_\_\_\_ No

What eases your pain? \_\_\_\_\_ What aggravates your pain? \_\_\_\_\_

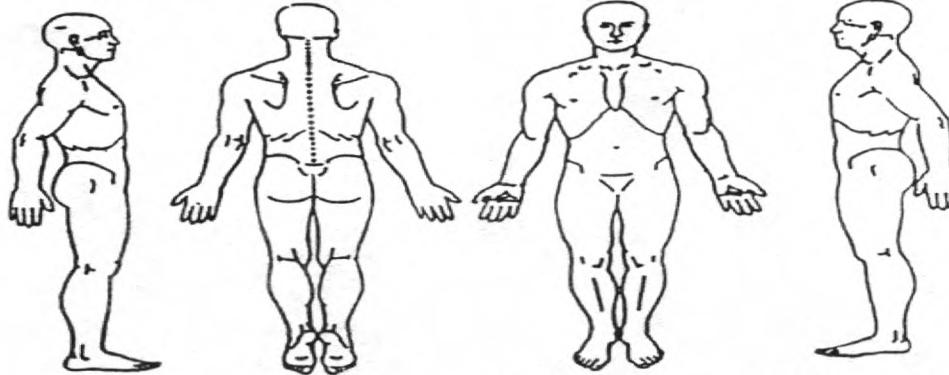
Do you have night pain \_\_\_ Yes \_\_\_ No (If yes: awakens you when you're still, moving or both? \_\_\_\_\_)

Are you better or worse as the day progresses? \_\_\_\_\_

Do you have dizziness, nausea, loss of balance, ringing in the ears or headaches \_\_\_\_\_

Do you feel you are getting better, staying the same or getting worse? \_\_\_\_\_

**WHERE IS YOUR PAIN? Please mark X's on the figure where your CURRENT symptoms are located:**



Please describe your current symptoms below:

\_\_\_\_\_  
\_\_\_\_\_

**Pain Intensity (Use #'s below to rate)**  
Least 0 1 2 3 4 5 6 7 8 9 10 Worst

Please list any recent tests for this complaint (X-ray, MRI, CAT Scan, Blood work, EMG, etc.)

Please list any past surgeries, injuries, or conditions you have been hospitalized or sought medical attention for: \_\_\_\_\_

	You	Family		You	Family
Cancer-Type?			Tuberculosis		
Hearing problem			Epilepsy		
Heart Problems			Multiple Sclerosis		
High Blood Pressure			Rheumatoid Arthritis		
Stroke			Other Arthritic Conditions		
Kidney Disease			Chemical Dependency		
Diabetes - Type?			Sleep Disorder		
Thyroid problems			Eating Disorder		
Hepatitis - Type?			Depression		
Anemia			Fibromyalgia		
Asthma			Constipation/Diarrhea		N/A
Emphysema/Chron.Bronchitis			Weight Gain/Loss (Past Year)		N/A
Immune Deficiency			Other		

Are you allergic to Latex, Adhesives or ultra sound gel? \_\_\_\_\_ Yes \_\_\_\_\_ No

Please list your personal goals for physical therapy \_\_\_\_\_

**REFERRALS**

This office cannot provide treatment to Medicare patients without a physician's order. All Medicare patients must provide us with a physician's order for treatment at the time of their initial visit. If an order cannot be obtained prior to your scheduled appointment, please call us to reschedule.

If your insurance coverage is an HMO plan, requiring authorization for treatment from your Primary Care Provider (PCP), we will assist you in maintaining a current treatment authorization; however, you must be aware that it is primarily your responsibility to know the limits on duration of treatment that your PCP has authorized and to work with your physician's office in obtaining extensions, should they be necessary, on authorizations that may expire during the course of treatment.

**INSURANCE BILLING**

As a courtesy to our patients we will submit all claims for your treatment to your insurance carrier(s). We will verify your insurance coverage and notify you of any deductible and/or estimated co-payment amounts for which you are responsible.

**CANCELLATION POLICY**

All appointments must be canceled twenty-four (24) hours in advance. Your compliance with this policy is very important, as someone else may be able to use your reserved time. If you have canceled more than once you may be billed \$20.00 for further cancellations.

**HIPPA**

Patient privacy posted in the waiting area of the front office. If you would like a copy we would be happy to provide a copy for you.

*If you have questions or concerns regarding any of the above policies, please feel free to discuss these with our office staff.*

I have read the above statements and fully understand the policies of Parker Physical Therapy regarding insurance claims and my responsibilities, physician referrals, cancellations and missed appointments. My signature acknowledges that I agree to the terms of this statement regarding payment for services and authorize Parker Physical Therapy to treat the named patient.

I have reviewed this consent form and acknowledge that I have been given the opportunity to review Parker Physical Therapy Notice of Privacy Practices. I give my permission to Parker Physical Therapy to use and disclose my health information in accordance with it. My signature acknowledges that I agree to the terms of this statement.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Insurance Benefits:**

As a courtesy to you, our patient, Parker Physical Therapy will verify your insurance benefits for Physical Therapy. Please note that benefit information given to us by your insurance provider is **NOT a guarantee** of benefits, all claims will be formally reviewed upon submission. It is the primary responsibility of the patient to be familiar with his/her insurance benefits, therefore we advise all patients to also verify their own insurance coverage for Physical Therapy.

If you have any questions regarding this policy and/or your insurance benefits, please ask a member of our Office Staff.

**WE APPRECIATE PAYMENT AT THE END OF EACH VISIT**