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 <u>do NOT</u> have your insurance card present.*

Insurance _____ ID # _____ Group # _____

Primary Subscriber: Name _____ Relationship _____ Date of Birth _____

****** PLEASE NOTE IF YOU HAVE NOT MET YOUR <u>DEDUCTIBLE</u> THERE WILL BE A CHARGE OF $75.00 FOR THE INITIAL EVALUATION AND THEN $65.00 PER VISIT ******

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 _____

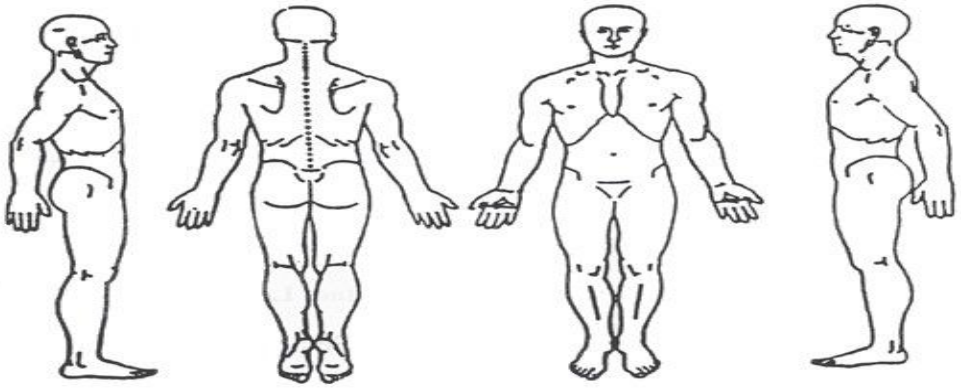
I authorize the release of any medical or other information necessary to process this claim I authorize payment of medical benefits to Parker Physical Therapy services provided to patient.

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 <u>CURRENT</u> 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