FLEX Physical Therapy

#480-306-7855

Brendanpt@flexpt1.com

Patient Information Sheet

Name:_____ Date of Birth:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone #:_____ Cell Phone#:_____

Email Address:_____

Medical Insurances

Member's Last Name: _____First Name: _____Date of Birth:_____

Relationship to patient: Self Parent Stepparent Legal Guardian Other

Member's Phone #:_____ Member's Employer: _____

Primary Insurance:_____ Member ID#:_____ Group#: _____

Insurance Billing Address:_____ Insurance Phone #:_____

Secondary Insurance:_____ Member ID#:_____ Group#: _____

Insurance Billing Address:_____ Insurance Phone #:_____

Emergency Contact Information

Person to notify in case of an emergency:_____

Phone #:_____ Relationship to patient:_____

****Medicare patients only****

Have you received any Home Health Care within the last 60 days? Yes_____ No_____

If yes, please list name of agency and discharge date_____

Was your injury due to any of the following:

Auto Accident_____ Work Comp_____ Accident on property other than your own_____

Accident details:_____

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Patient Medical History

Name:_____ Onset date of illness:_____

Is injury related to a motor vehicle accident? Yes ____ No ____

Primary Care Physician:_____ Referring Physician: _____

Have had surgery for this condition? Yes____ No ____ Type of surgery:_____

Are you currently taking any prescription or non-prescriptions? Yes____ No ____

Ant-inflammatory _____ List of medications: _____
Muscle Relaxers _____ (include dose and _____
Pain Medication _____ frequency) _____

Please check if you have had any of the following medical/rehabilitative service for this condition:

- MRI/CT Scan
- EMG/NCV
- X-Ray
- Other Diagnostic Test _____
- Chiropractor
- Emergency Room Care
- General Practitioner
- Massage Therapy
- Neurologist
- Occupation Medicine Doctor
- Occupational Therapy
- Orthopedist
- Physical Therapy
- Podiatrist
- Other:_____

Please check if you have a history of any of the following:

- Anemia
- Asthma/Bronchitis/Emphysema
- Blood Clot/Emboli
- Cancer or Chemo/Radiation
- Diabetes
- Emotional/Psychological Issues
- Epilepsy/Seizures
- Heart Attack or Heart Surgery
- Heart Disease or Angina
- High Blood Pressure
- Infectious Disease
- Pacemaker
- Shortness of breath/chest pain
- Sleeping Problems/Disorders
- Stroke/TIA
- Thyroid Trouble/Goiter
- Tuberculosis
- Allergies
- Bowel or Bladder Problems
- Dizziness or Fainting
- Hernia
- Numbness or Tingling
- Severe or Frequent Headaches
- Varicose Veins
- Vision or Hearing Difficulties
- Weakness
- Weight Loss/Energy Loss
- Any Pins or Metal Implants
- Arthritis/Swollen Joints/Gout
- Back Injury/Surgery
- Elbow/Hand Injury/Surgery
- Joint Replacement
- Knee Injury/Surgery
- Leg/Ankle/Foot Injury/Surgery
- Neck Injury/Surgery
- Osteoporosis
- Shoulder Injury/Surgery

Have you had 2 or more falls in the last year or any fall with an injury in the last year? Yes____ No____

Are you aware of your diagnosis? Yes _____ No _____ Are you pregnant? Yes____ No____

Any hospitalizations in the last year? _____

Patient/Guardian Signature:_____ Date: _____

I have reviewed this medical history: _____
Therapist Signature

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CONSENT FOR CARE AND TREATMENT

I, the undersigned, agree and give my consent to ***FLEX*** **Physical Therapy** to provide medical care and treatment to

_____ considered necessary and proper in diagnosing or treating his/her physical condition.
Patient's printed name

Patient/Guardian/Responsible Party Signature_____ Date_____

PRIVACY PRACTICES

By initialing here, I acknowledge that ***FLEX*** **Physical Therapy's** has a Notice of Privacy Practices and can be

provided upon request. _____
Initials

TEXT MESSAGE REMINDERS

I agree and give consent to receive text message reminders for my appointments. _____
Initials

CANCELLATION/NO SHOW POLICY

There will be a $50 cancellation/no show fee if you are unable to make your appointment without giving at least 24 hours prior notice. To cancel, please call the office at: **480-306-7855**. By signing below, I acknowledge this policy.

Patient/Guardian/Responsible Party Signature_____

NOTIFICATION OF PATIENT FINANCIAL RESPONSIBILITY

If you have elected to pay for your treatment at ***FLEX*** **Physical Therapy** out of your own pocket, payment is due to ***FLEX*** **Physical Therapy** at the time of service. The following are self-pay fees for services you would be responsible for:

Initial Evaluation:	$150.00
Subsequent Visits:	$100.00

If you have elected to use insurance, we will provide an estimate of costs after doing an insurance verification. However, these are only estimates and the total patient financial responsibility amount is based on how PT claims are processed by the insurer. Here are the estimated costs you may be responsible for:

Initial Evaluation:	$_____
Subsequent visits:	$_____

In the event that a check is returned for Non-Sufficient Funds, a $35 service fee will be charged to you.

Please verify that you understand your financial responsibility by signing and dating this form:

I understand and agree that if I fail to make any of the payments, in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

Patient/Guardian/Responsible Party Signature _____Date_____

Clinic Representative _____Date_____