REMOBILITY PHYSICAL THERAPY

PATIENT INFORMATION

(Please print clearly.)

TODAY'S DATE: / / NAME: Last: First: MI:

Please present government issued ID and insurance cards to the Office Assistant for copying.

MAILING ADDRESS:

CITY/STATE/ZIP:

MARITAL STATUS: S M W D BIRTH DATE: / /

PRIMARY PHONE#: Is this: HOME WORK CELL

ALTERNATE PHONE#: EMAIL:

May we send patient information and office notifications to you via email? YES NO

Where may we leave voice messages for you? (Circle all that apply) PRIMARY ALTERNATE

EMPLOYER/SCHOOL:

OCCUPATION:

REFERRING PHYSICIAN NAME: PHONE #:

Would you like us to share reports with another healthcare provider such as your primary physician?

If yes, please list here:

★ Who should we contact in case of emergency?

Person's relationship to you: PHONE #:

★ If the above person cannot be reached, who should be next?

Person's relationship to you: PHONE #:

ACCIDENT WHILE WORKING: DATE OF INJURY: / /

EMPLOYER CONTACT: PHONE #:

CLAIMS HANDLER: PHONE #:

CLAIM #: Are you currently on leave of absence? YES NO

AUTO ACCIDENT: Please provide auto insurance info (primary) and personal health insurance (secondary). A copy of your police report is required for injury documentation. We do not accept attorney liens or 3rd party insurance. ACCIDENT DATE: / /

CLAIM HANDLER: PHONE#:

CLAIMS ADDRESS:

CITY: STATE: ZIP: FAX#:

HOW DID YOU FIND US? (Specify) Search Engine_____ Physician _____
Insurance Provider Directory _____ Advertisement_____
Building Sign_____ Friend/Family (who?)_____
Other:

THANK YOU FOR CHOOSING OUR OFFICE AND COMPLETING THE ABOVE INFORMATION. PLEASE PLAN TO PAY ALL CO-PAYS AND DEDUCTIBLES AT EACH VISIT. WE PROMISE TO PROTECT YOUR PRIVACY AND PROVIDE YOU WITH COMPETENT, CARING SERVICE.

REMOBILITY PHYSICAL THERAPY
3901 Roswell Rd Ste 100A, Marietta GA 30062-8811
Tel: 770-578-4343, Fax: 770-578-4342
www.remobility.com

TREATMENT & FINANCIAL POLICIES

Welcome to Remobility! We are glad that you have chosen us for your physical therapy and wellness needs. Please read each section thoroughly and initial beside it if you understand and consent. If you have any questions, please speak with our staff.

CONSENT FOR TREATMENT

I, the undersigned, authorize Roël Fung-A-Wing, PT, or a qualified substitute to administer evaluation and treatment as is necessary. I attest that I am not currently under the care of a Home Health Agency; if I should receive Agency care, including nursing services, I will immediately notify Remobility Physical Therapy. I understand that no guarantee has been made as to the results of therapy, which may include modalities, exercise, manual techniques or certain functional activities. I understand that there are some risks and benefits of said treatment, that I have the right to ask questions about any procedure and that I may refuse treatment at any time.

_____
INITIALS

APPOINTMENTS

Office hours are by appointment, Monday – Friday, 7:30am – 5:00pm. Remobility does adapt this schedule from time to time according to patient needs, holidays or unforeseen occurrences. We respect our clients' time and will make every effort to see each person as promptly as possible. Late arrival for an appointment may result in a shortening or reduction of treatment services for that visit. Arriving for an appointment more than 10 minutes late without notifying our office may result in rescheduling the appointment.

_____
INITIALS

CANCELLATIONS: I understand that if I must cancel an appointment, I should give 24 hours notice as a courtesy to the patients and staff of Remobility. If I am unable to attend a scheduled appointment, ***I will notify Remobility Physical Therapy a minimum of 4 hours in advance***. ***Without such notice, I agree to pay a $30 non-cancellation fee prior to beginning my next visit***. I understand that this charge is not billable to my insurance company.

PAYMENT FOR SERVICES

Remobility's fees are based on industry standards in the metro Atlanta area. For patient payments we accept cash, personal checks drawn on Georgia accounts, money orders, Visa, MasterCard, and Discover. For patients who have insurance, we will gladly submit claims on their behalf; however co-payments, co-insurance, and deductible amounts will be **estimated** and collected at the time of service. Patients will be billed for any balances owed after claims have been processed by the insurance company. If the insurance statement indicates that the patient portion had previously overpaid at the time of service, then the patient may either choose to have this amount applied as a forward credit on their patient account in our office, or to have this amount refunded directly to them. Unless prior arrangements have been discussed, all payments will be due at the time of service.

_____
INITIALS

ASSIGNMENT OF INSURANCE OR OTHER BENEFITS

I understand that physical therapy treatment, if covered by my insurance plan, may require a written order/prescription from my physician or surgeon or an advance authorization from my insurance company. I further understand that if a referral or pre-authorization is required, then this must be submitted to Remobility before I begin treatment, otherwise, the visit(s) may not be reimbursed by my insurance company and therefore I must pay for unauthorized visits in full at the time of service.

_____
INITIALS

I certify that the information I have provided Remobility Physical Therapy for payment of services is correct. I understand that my insurance plan is a contract between me and my insurance company, and therefore I am ultimately responsible for the cost of my treatment with Remobility. I hereby give authorization to this clinic to submit claims to insurance or other third party on my behalf, as well as seek payment for provided services. I authorize Remobility to assign my insurance benefits to this clinic and deposit such payments to satisfy my account balance for services rendered.

If my insurance coverage changes, it is my responsibility to inform the clinic immediately. I agree to pay my share of my financial obligation in a current manner. I realize that I am responsible for all charges billed, including those not paid by said insurance company. I am also responsible for any interest, collection, attorney, or legal fees incurred to collect payment for services rendered.

PRIVACY OF INFORMATION

I understand that certain information about my care may be shared by Remobility Physical Therapy with insurance companies, attorneys, or employers. I authorize Remobility Physical Therapy to release such information as is necessary. I authorize Remobility Physical Therapy to keep a photo of me in my medical records for identification purposes.

_____
INITIALS

In the instance of an accident or injury case, it may be necessary for our therapy staff to photograph me for my therapeutic record. These photos may be shared with insurance carriers or attorneys when requested, to ensure payment and/or for educational purposes. I have been made aware of my rights under the federal privacy act and understand that Remobility Physical Therapy will make every effort to protect those rights.

I have thoroughly read and agree to the above TREATMENT & FINANCIAL POLICIES.

_____ _____
Print name of Patient and/or Guardian Date

_____
Signature

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PATIENT MEDICAL HISTORY

NAME: _____ DATE: _____

Date of Birth: _____Weight: _____ Height: _____ Occupation: _____

My daily activities involve: ____hrs. standing ____hrs. sitting/driving ____hrs. computer use/typing ____hrs. phone use ____hrs. lifting/reaching/bending ____hrs. walking/exercise ____hrs. sleeping

Drug/Supplement Allergies:_____

Environmental/Food Allergies: _____

Special Diet _____

State of health: ____Excellent ____Good ____Fair ____ Poor Are you currently on disability? _____

Medications/Supplements you are currently taking: (Please give copy of list to therapist, if you have one)

_____

_____

Healthcare providers you have seen within the last year: **Specialty:**

_____ _____

_____ _____

_____ _____

_____ _____

Conditions you have experienced (**please check twice if this has occurred within the last 6 months**):

____Anemia
____Arthritis ___Degenerative ____Rheumatoid
____Asthma____Triggered by Exercise
____Bleed Easily
____Bone Fractures_____
____Brain Injury/Stroke
____Cancer of_____
____Chronic Constipation
____Chronic Depression
____Chronic Diarrhea
____Chronic Leg cramps
____Chronic Urine Leakage
____Diabetes Type __I __II
____Drug/Alcohol Addiction
____Epilepsy/Seizures
____Fibromyalgia
____Heart Pacemaker
____Heart Problems_____
____High Blood Pressure
____HIV/Aids
____Low Blood Pressure
____Osteoporosis
____Parkinson's Syndrome
____Repeated Infections_____
____Smoke cigarettes/cigars_____per day
____Vascular Problems
____Other_____

Please list any previous surgical procedures and give the approximate dates.

Procedure **Date**

_____

_____

_____

_____

_____

REMOBILITY PHYSICAL THERAPY

HEALTH QUESTIONNAIRE

Patient: _____ Date of Birth: _____

1. Please describe the health problem you are having that requires physical therapy:

_____

_____

2. When did your current problem begin? _____ Is it a returning problem? YES NO

3. Is your current physical therapy situation the result of (check all that apply):

__Auto accident __Injury/accident while working __Sports injury __Pregnancy/Childbirth
__Accident at home __Injury/accident while at school __Rehabilitation after surgery
__Effects of illness or medical condition __Other_____

4. What symptoms are you experiencing with your current problem? (check all that apply)

__Sharp pain __Shooting pain __Dull ache __Numbness __Tingling sensation __Pounding pain
__Swelling/edema __Joint stiffness __Muscle spasm __Muscle tightness __Soreness
__Other_____

5. Are your symptoms: __Localized (stays in one area) __Radiating (starts in one area & spreads out)

6. What areas of your body are affected by the above symptoms? Please rank in order (1, 2, 3, etc.) with 1 being the body area with the worst pain or problem. If a body area does not have a problem, please leave the space blank.

__Head/face __Neck/throat __Shoulder __Upper arm __Elbow __Forearm __Wrist
__Hand/fingers __Upper back __Middle back __Side/ribs __Lower back __Hip/buttock
__Upper leg __Knee __Lower leg __Ankle __Foot/toes __Chest __Abdomen __Groin

7. How often do you experience symptoms?

__Constantly (76-100% of the day) __Frequently (51-75% of the day)
__Occasionally (26-50% of the day) __Intermittently (0-25% of the day)

8. During the past 24 hours, what is the average intensity of your symptoms? (please circle)

(None) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable)

9. What makes your symptoms worse and when? (check all that apply)

__Sitting __Standing __Bending __Walking __Reclining/Lying down __Lifting __Position change
__Morning/Waking __Mid-day __Evening __Warm weather __Cold weather __Other_____

10. Who have you seen for your current problem? (check all that apply)

__No one __Medical doctor __Other physical therapist __Chiropractor __Other_____

11. What treatments and tests were performed by the above providers? (check all that apply)

__X-rays __CT Scan __MRI __Nerve study __Surgery __Injections __Medication __Splint/brace

__Chiropractic adjustments __Acupuncture __E-stim/TENS __Massage __Laser/ultrasound therapy

__Other_____

Patient Signature:_____ **Date:**_____

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