Caribou Physical Therapy Patient Information

Personal Information

Date: ___________ Male Female Height______ Weight______ Single Married Widowed
Last Name: ________________________ First Name: ________________________ MI: ____________
Address: ____ Mailing if Different: ________________
City: ____________________________ State: _______________________ Zip: ___________________
Birthdate: ___________________ Age: ___________ Social Security Number: ____________________
Home Ph#: ________________ Cell: ________________ May we leave a message on Home# Y__N__ Cell# Y__N__
Employer: _______________________ Work Ph#: ____________ Spouse Employer: _________________
Spouse/Emergency Contact: _______________________________________ Ph#: ____________________
Relationship to You: ________________ If a Minor, Parent/Guardians Name: ________________________

Medical Information

Referring Physician: ____ Ph#: ______________________
When did you last see your physician? ________________________________
Diagnostic Test Done & Date: X-rays: __________ MRI: __________ CT Scan: __________ Other: _________
Have you recently had a steroid or cortisone injection? Y N Date: ______________________________
What is your general health: Poor Fair Good Excellent
Medications: ____
Allergies: ____
Injury: Y N Date: ____________________ Please explain where & how the injury occurred: _____________
____
What is your diagnosis? (Check and circle which side)

□ Low Back R L □ Knee R L □ Foot R L
□ Neck □ Hip R L □ Elbow R L
□ Upper Back R L □ Buttock R L □ Wrist R L
□ Shoulder R L □ Ankle R L □ Hand R L

Other (Describe): ____
Have you had previous therapy? Y N Where? ____
Surgery: Y N Date: ______________ What Type? ____
Any Prior Injury? Y N Date: _____________ Describe: ______________________________________

Billing Information

Insurance Company Name: ____ Ph#: _________________
Policy Holders Name: ____ Date of Birth: ______________
Policy or Member ID Number: ______________________________ Group Number: _________________
Insurance coverage as the result of an auto (or other) accident? Y N

Continued on other side

Medical History

Do you have or have you recently had any of the following conditions?

__ Arthritis
__ Asthma
__ Blood Disorders
__ Broken Bones/Fractures
__ Cancer
__ Cellulitis
__ Congestive Heart Failure
__ COPD
__ Deep Vein Thrombosis/PE
__ Depression
__ Developmental or Growth Problems
__ Diabetes
__ Dizziness
__ Eating Disorder
__ Emphysema
__ Stroke/TIA
__ Fibromyalgia
__ Gastro-Esophageal Reflux Disease

__ Head Injury
__ Headaches
__ Heart Attack/MI
__ Heart Disease
__ Hearing Impairment
__ High Cholesterol
__ High Blood Pressure
__ Infectious Disease
__ Kidney Problems
__ Liver Disease
__ Low Back Pain
__ Low Blood Pressure
__ Lymphedema
__ Multiple Sclerosis
__ Muscular Dystrophy
__ Obesity
__ Osteoarthritis

__ Osteoporosis
__ Pacemaker
__ Parkinson Disease
__ Peripheral Neuropathy
__ Pregnant
__ Psychiatric Disorders
__ Repeated Infections
__ Seizures/Epilepsy
__ Spinal Cord Injury
__ Skin Diseases
__ Stomach Problems/Ulcers
__ Sudden Weakness
__ Swallowing Difficulties
__ Stroke
__ Thyroid Problems
__ Vision Impairment
__ Other: _______________

Caribou Physical Therapy has an open gym where multiple patient-physical therapist communications routinely occur. Several patients may be receiving exercise therapy at the same time. The staff will do reasonable safeguards to provide privacy of your protected health information. If at any time you feel that a more private setting is needed for detailed discussions of treatment and prognosis, please let your therapist know so that a more private area can be provided. For more details of the HIPAA regulations, please review the "Notice if Privacy Practices" handout. Thank you for choosing Caribou Physical Therapy to assist you with your physical therapy needs.

FINANCIAL ARRANGEMENTS

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. Billing statements will be sent to you on or about the 1st of each month. All accounts are due and payable upon receipt of statement unless other arrangements are made at the time of service. Interest will be added to all accounts 30 days past due. Accounts 90 days pas due will be sent to a collection agency.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Caribou Physical Therapy to furnish my insurance company or a designated attorney all information that they may request regarding my condition when under their observation, treatment, or care, including history, findings, and treatment. A copy of this authorization may be accepted with the same authority as the original.

ASSIGNMENT OF BENEFITS

I hereby authorize payment of medical benefits to Caribou Physical Therapy for the services provided to me. I understand that I am financially responsible to Caribou Physical Therapy for charges not covered by this assignment.

I hereby assign to Caribou Physical Therapy all money which I am entitled for medical treatment expenses relative to the service rendered by them in the event of a settlement.

The undersigned authorizes the staff of Caribou Physical Therapy to undertake such treatment and procedure as deemed appropriate to remedy or improve the condition of the patient in the professional judgment of Caribou Physical Therapy licensed staff. Such treatment and procedure shall be as directed by the referring physician as necessary. I have read (or had read to me) the above information. I understand the content. I give consent to such treatment under these conditions willingly and knowingly.

Signed: ____ Date: __________________________