ADDISON WELLNESS PATIENT INFORMATION

231 Court Street Middlebury, VT 05753 802-388-3533

Name: _____ Date of Birth: _____
Last First M.I.

Address: _____Town:_____ State: _____ Zip Code: _____

Home phone: ( ) _____ Cell phone: ( ) _____

E-Mail Address: _____ Preferred Pronoun: _____

Do you want to receive appointment reminders? Choose One: ___Text to cell **OR** ____email **OR** ____Voice Msg

Employer: _____ Occupation: _____

Phone: ( ) _____

Person to notify in case of emergency: _____ Relationship: _____

Address: _____ Phone: ( ) _____

Family Physician: _____

Insurance Information: Name of Insurance(s): _____

Primary Card Holder Name:_____

Primary Card Holder Date of Birth: _____

Responsible Party for Bills: _____

Social Security Number *(if billing Medicare or Medicaid)*: _____

Were you injured at work? Yes _____ No _____ Was this an auto accident? Yes ____ No _____

Date of accident, if applicable: _____

Billing Policy & Agreement: We will submit insurance claims for treatment provided as a courtesy to you**. It is your responsibility to know the limitations and requirements of your policy.** Insurance companies may at times deny payment for some types of therapy that your physician, you, and your therapist know are essential. Your insurance policy may require pre-authorization, a deductible and/or copayment to be met before the carrier will pay for the balance of what they allow for therapy. When we receive payment from the carrier, you will be billed for the difference plus your deductible and copayment if you have not met them for the calendar year according to the rules of your insurance carrier. Should you have questions regarding our billing policy, please contact us. Should your circumstances be such that this agreement creates a hardship, please contact us to work out an acceptable agreement. **I have read and understand this information and agree to meet my obligations for payment of my co-insurance, deductible, and otherwise uncovered portions of my bill, except where specifically excluded by agreement with my insurance carrier.**

Signature of Patient/Legal Guardian: _____Date:_____

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PATIENT HEALTH INFORMATION

(This questionnaire is considered a part of your confidential medical records)

Patient Name: _____ D.O.B. _____

1. What is your present injury or issue?: _____
2. Is it on your ____Right Side ____Left Side ____Both Sides ____Not Applicable
3. When did your injury or issue occur?: _____Date:_____
4. How did your injury or issue occur?: _____
5. Where were you when it occured?: _____
6. Have you undergone diagnostic tests(Xray, MRI etc..) for this current condition? ___Yes ___No
   (If yes, what and where can the report be located? _____)

7. Please rate your pain: 0 being 'No Pain' and 10 being 'hospitalization'.

 0 1 2 3 4 5 6 7 8 9 10  At its Worst

 0 1 2 3 4 5 6 7 8 9 10  Currently

 0 1 2 3 4 5 6 7 8 9 10  At its Best

MEDICAL HISTORY: (Please check if **you** have a history of)

_____ High Blood pressure	_____ Heart Disease	_____ Chest pain/Angina
_____ Asthma/Lung disease	_____ Shortness of breath	_____ Thyroid Condition
_____ Arthritis	_____ Diabetes	_____ Low blood sugar
_____ Headaches	_____ Cancer	_____ Osteoporosis/penia
_____ Smoker ____ packs per ____	_____ Fractures (Broken bones)	_____ Impaired vision
_____ Unusual joint pain/swelling	_____ Impaired hearing	_____ Epilepsy
_____ HIV / AIDS	_____ Hepatitis	_____ Currently pregnant
_____ Pacemaker or electronically sensitive device		_____ Other

8. Do you have any problems with your bowels or bladder? _____No _____Yes

9. Do you have an allergy to latex? ____ Yes ____No Other Allergies: _____

10. Have you had any previous surgeries? If yes, what: _____

11. In choosing physical therapy services, what do you hope to achieve? _____

The medical history information I have provided for the physical therapist is true and complete to the best of my knowledge. I understand it is my responsibility to keep the treating physical therapist updated on my medical condition and history. I agree and give my consent for Addison Wellness to provide physical therapy evaluation, care and treatment considered necessary and proper in diagnosing and /or treating my physical condition.

Signature: _____ **Date:** _____

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MEDICATIONS LIST

Please include all Prescription, over-the-counter, herbal and vitamin/mineral dietary supplements.

Patient Name:_____ Date: _____

☐ **My Medications Have Not Changed Since My Last Visit**

Medication Name	**Dosage**	**Frequency**	**Route** i.e.—Oral, Injection

I attest that the documented current medication information is accurate and complete to the best of my knowledge and ability at the time of this appointment.

Patient
Signature:_____

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Patient Authorization to Use or Disclose Protected Health Information

I, _____, authorize Addison Wellness or its Business Associates to use or disclose my protected health information as described below to the recipients indicated.

_____
(physician name)

Other recipients of information? (Spouses, family members, chiropractor, massage therapist etc..):_____
_____

I authorize Addison Wellness to call me or leave messages at the following

number(s) _____.

I, _____, understand that Addison Wellness creates and maintains health records describing my medical history, diagnoses, evaluation results, treatment, and plans for future treatment. This information may serve as: a basis for planning my care and treatment, a means of communication among health professionals who contribute to my care, a source of information for applying my diagnosis and treatment information to my bill, a means by which a third-party payer can verify services billed were provided, and a tool for routine healthcare operations such as assessing quality. A ***Notice of information Practices*** that more completely describes how your medical information may be used or disclosed is displayed throughout the clinic and copies are available to you upon request.

I have read and fully understand and accept the terms of this authorization. I acknowledge that I have been offered a full copy of the Addison Wellness HIPAA policy for Use or Disclosure of Protected Health Information

_____ _____
Signature of Patient or Legal Guardian *Date*

Cancellation and Attendance Policy

WE REQUIRE 24 HOURS NOTICE if you need to miss an appointment. Life can at times be busy, and at times, other issues/illness can get in the way of your appointment. We provide reminder emails, text messages, and phone calls to assist in your scheduling or attendance. If you will not be able to attend, please give us the courtesy of time to contact someone else who has requested our assistance if you cannot attend. FAILURE TO NOTIFY US, OR MULTIPLE DAY-OF CANCELLATIONS may result in **a fee of $50 per appointment missed and/or in the discontinuation of care**. Arriving late to an appointment may also constitute a missed appointment.

I have read and I understand the expectations regarding attendance:

Signature: _____ Date:_____