WELLS PHYSICAL THERAPY SERVICES PATIENT INFORMATION

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

Name: _____ Social Security Number: _____
Last First M.I.

Date of Birth: _____ Age: _____ Sex: _____ M _____ F

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

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

E-Mail Address: _____

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

Employer: _____ Occupation: _____

Phone: ( ) _____

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

Address: _____ Phone: ( ) _____

Family Physician: _____

Whom may we thank for referring you to this office? _____

Insurance Information: Name of Insurance(s): _____

Primary Card Holder Name:_____

Primary Card Holder Date of Birth: _____

Responsible Party for Bills: _____

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

Date of accident, if applicable: _____

Consent for Physical Therapy Treatment

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 Wells Physical Therapy Services to provide physical therapy evaluation, care and treatment considered necessary and proper in diagnosing and /or treating my physical condition.

Signature of Patient/Legal Guardian: _____Date:_____

Wells Physical Therapy Services **231 Court Street Middlebury, VT 05753 802-388-3533**

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? _____

_____

Signature: _____ **Date:** _____

Wells Physical Therapy Services **231 Court Street Middlebury, VT 05753 802-388-3533**

MEDICATIONS LIST

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

Patient Name:_____ Date: _____

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:_____

Patient Authorization to Use or Disclose Protected Health Information

I, _____, authorize Wells Physical Therapy Services 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 Wells Physical Therapy Services to call me or leave messages at the following number(s) _____.

I, _____, understand that Wells Physical Therapy Services 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. You have the right to review this notice prior to signing this consent. Wells Physical Therapy Services reserves the right to change its notice and practices. If this occurs during the course of your treatment here, a revised statement will be brought to your attention.
You have the right to request restrictions as to how your health information may be used or disclosed to carry out treatment, payment, or healthcare operations. You may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

When information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may then no longer be protected health information. You have the right to inspect or copy the information to be used or disclosed and may refuse to sign this authorization. You have a right to revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization. In order for the revocation to be effective, Wells Physical Therapy Services must receive a signed, dated revocation in writing.

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 Wells Physical Therapy HIPAA policy for Use or Disclosure of Protected Health Information

_____ _____

Signature of Patient or Legal Guardian *Date*

Wells Physical Therapy Billing & Payment Agreement

We require payment of copays, equipment and non-covered services at the time of your visit

You are responsible for:

* Knowing your insurance coverage terms & benefits for treatment in our clinic.
* Providing accurate and up to date insurance coverage information to Wells PT for the purpose of billing your visits.
* **You are directly responsible for payment of services you receive from Wells Physical Therapy Services.** This may include copays, deductibles & coinsurances as well as non-covered services. Other items **not often** covered by insurance can include equipment **vital to our therapy, both for your home and in-clinic program**. This could include ***theraband, balls, electrodes, kinesiotape and heel lifts***. You and your therapist will discuss the medical necessity of these items at the time of your visit.
* You are responsible for obtaining any referrals or scripts required by your insurance company in order to pay for your services here at Wells.

We Bill Your Insurance:

As a courtesy to you, our billing department will submit your visit fees rendered at this office to your health insurance company in a timely manner. Please be advised that your insurance policy is a **contract between you and your insurance company.** Any verification of benefits we do on your behalf is not final until the insurance company has received the claim and adjudicated. If you ever have any questions regarding your coverage, please contact your insurance company directly.

Your Wells PT Bill:

For those services not collected at the time of your visit, Wells Physical Therapy will send you a monthly statement. Payment of your statement balance is due at the time of receipt unless a payment plan agreement has been signed with the billing manager.

You Can Pay Your Bill With:

*Cash & Personal Check
*Debit Cards
*Visa, Mastercard, Discover, Amex
*HSA Cards

I have read and understand the preceding information and agree to meet my obligations for payment of the services I have accepted at Wells Physical Therapy. I authorize the release of any medical or other information necessary to process my treatment claims and authorize payment of medical benefits to Wells Physical Therapy.

_____ _____

Signature Date