Australian Physiotherapy
SPECIALISTS
Advanced Spine & Orthopedic Physical Therapy

Name: _____ Date of Birth: _______________

Address: _____ Soc. Sec# (last 4): _____

City: _____ State: _____ Zip: _____

Home Ph.: _____ Work Ph.: _____ Cell: _____

Email Address: _____

Insured Person's Name: _____ DOB: _____

Emer. Contact Name & Ph.: _____

Employer: _____ Work related injury? Y N

Referred By: _____ Motor vehicle accident? Y N

Primary Ins. & ID: _____

Secondary Ins. & ID: _____

****

Chief complaint:

_____

_____

_____

_____

Date of Injury or Surgery: _______________

How did injury occur? _____

_____

By signing below,

I consent to treatment at Australian Physiotherapy Specialists (or treatment of child if signing as parent/guardian).

I authorize Australian Physiotherapy Specialists to release medical information to my insurance and my referring physician and/or Primary Care Provider. Please provide information below if available.

Referring Physician Name, Phone, and Fax:

N.: _____ P.: _____ F.: _____

PCP Name, Phone, and Fax:

N.: _____ P.: _____ F.: _____

Insurance/Payments:
Your insurance plan is a contract between you and your insurance company. We are not party to this contract. The service(s) you have elected to participate in implies a financial responsibility on your part. As a courtesy, we will verify eligibility and submit health insurance claims on your behalf. If authorization is required for services, it is your responsibility to make yourself aware of this and ensure that an authorization is in place at the time of your services. Medicare patients are required to have a physician's order on file so we can submit the claim to Medicare. You are ultimately responsible for payment of your bill. We will not become involved in disputes between you and your insurance company. **If you are entitled to receive benefits arising out of a policy insuring you or another party's liability to you, you hereby assign said benefits to Australian Physiotherapy Specialists to be applied to your bill**. If you receive a check from your insurance company for our services, you agree to supply included information and exact payment to our office within 5 business days. Cashing such a check and never remitting payment to our office is fraudulent.

I authorize Australian Physiotherapy Specialists to bill and collect payments from my insurance company.

I agree to accept financial responsibility for my treatment including co-pays, co-insurances, and deductibles to be paid at check-in on the date of service.

Cancellation Policy:
I understand that any appointment not rescheduled and/or cancelled **Monday through Friday 8AM-5PM with at least 24 hour notice** will result in a charge of **$65.00** per missed visit. This fee, if assessed, will be collected over the phone prior to rescheduling or at the next visit.

HIPAA Verification:
I acknowledge that at my request I can view a copy of the "Federal Notice of Information Policies" (HIPAA Guidelines)

I acknowledge the health and personal information documented herein is true to the best of my knowledge.

Signature: _____

Printed Name: _____

Date: _______________

PATIENT HISTORY

NAME: _____ DOB: _____
DATE OF NEXT MD APPOINTMENT: _____

Describe briefly the history of your present ACCIDENT, INJURY, and ILLNESS OR CONDITION
Onset Date: _____

_____
_____
_____
_____

Please list any special concerns, questions or expectations:

_____
_____

Have you fallen in the past year? _____ If so, how many times? _____
If so, did you sustain an injury? _____
_____

Have you been or are you currently under chiropractic care within the last 6 mos.? _____

Have you had ANY physical therapy elsewhere during the current calendar year? _____
Have you had physical therapy for the same condition for which you are here today? _____
If yes, please indicate where and when:

_____
_____

Please list recent diagnostic studies (CAT scan, MRI, X-ray, Etc.)

_____
_____
_____

Do you have METAL anywhere in your body (other than teeth), such as pins/plates, pacemaker, stents, etc.? Describe:_____
_____
_____

Please list **ALL** surgeries you have had; please give procedures and dates, if possible: _____
_____
_____
_____
_____

PATIENT HISTORY – Page 2

Have you ever had: (Please circle yes or no)					
High blood pressure	Yes	No	Arthritis/Osteoarthritis	Yes	No
Heart Disorders	Yes	No	Osteoporosis	Yes	No
High Cholesterol	Yes	No	Cancer	Yes	No
Lung Disorders	Yes	No	Pacemaker	Yes	No
Circulation Disorders	Yes	No	Are you pregnant?	Yes	No
Dizzy Spells	Yes	No	Allergies to tapes or lotions?	Yes	No
Seizures	Yes	No	Recent Weight Loss	Yes	No
Diabetes	Yes	No			

Signature: _____

Printed Name: _____

Date: _______________