TRI-LAKES PHYSICAL THERAPY NEW PATIENT INFORMATION

First Name _____ **MI** _____ **Last Name** _____

Nickname _____ **Spouse Name** _____

Address _____

City _____ **State** _____ **Zip** _____

Gender ☐ Male ☐ Female

Date of Birth _____ **Age:** _____ **Occupation** _____

Social Security # _____ **Employer** _____

Home Phone _____ **Work Phone** _____

Cell Phone _____ **Email** _____ ☐no thanks

Referring Doctor: _____ **Family Doctor:** _____

Emergency Contacts (2)

Name _____ **Name** _____

Relation _____ **Relation** _____

Home Phone _____ **Home Phone** _____

Employer _____ **Employer** _____

Work Phone _____ **Work Phone** _____

How did you hear about us? _____

Please mark all that apply:

☐ Pacemaker ☐ Pregnancy ☐ High or Low Blood Pressure

☐ Do you smoke? ☐ Deep Vein Thrombosis ☐ Skin Trouble (open sores, wounds, delicate skin)

☐ Are you incontinent of bowel or bladder?

If you have had any orthopedic surgeries in the past, please list what kind, what doctor, and when it took place

_____

_____

Is this injury related to: ☐ Employment ☐ Vehicle Accident ☐ Other

Have you had any PT or chiropractic this year? ☐ Yes ☐ No
If yes, when and where?

_____

What medications are you currently taking? (Or, provide us with a list if you have one.)

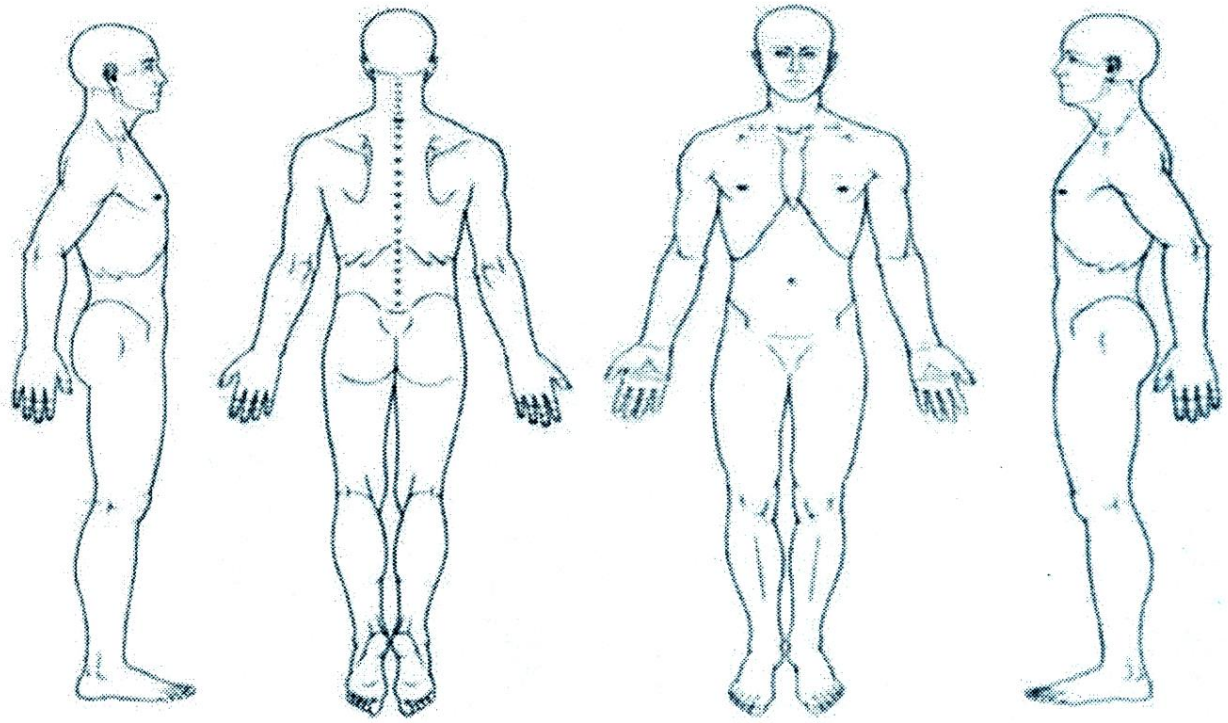
_____

_____

(If more space is needed, please write on the back of the page.)

Patient Questionnaire **Patient:** _____

Please mark any areas where you are currently experiencing symptoms:



Did your problems start suddenly? __yes __no If yes, for how long, and when did they start?

_____

_____

Have you experienced these symptoms for a long time? __yes __no If yes, for how long, and have they gradually worsened?

_____

_____

Date of injury: _____ ☐N/A Date of surgery: _____ ☐N/A

When do you go back to your doctor? _____

Tri-Lakes Physical Therapy

Consent for Treatment

I give consent to Tri-Lakes Physical Therapy to evaluate my condition and administer treatment, or medical devices as deemed necessary.

Release and Disclosure of Health Information

I authorize Tri-Lakes Physical Therapy to receive protected health information from other medical providers or sources necessary for performing healthcare operations, establishing diagnosis, or for the purpose of providing payment for services rendered. I also authorize Tri-Lakes Physical Therapy to disclose protected health information to other medical providers or sources necessary for performing healthcare operations, establishing diagnosis, or for the purpose of providing payment for services rendered.

Protected health information can include demographic data collected from me or from another healthcare provider, health plan, employer, or a health care clearing house. This protected health information relates to past, present, and future physical or mental health conditions which identify me, or there is a responsible basis to believe the information may identify me. By my signature, I authorize the use and disclosure of such information.

This authorization shall be in effect for an extent of time necessary for Tri-Lakes Physical Therapy to carry out prescribed treatment, to complete payment for services rendered, or for providing information to authorized agencies. I understand if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

I understand that I have the right to revoke or place restrictions on how my protected health information is used or disclosed, in writing, at any time by sending notification to: Tri Lakes Physical Therapy, 307 Carpenter Dam Rd. Bldg. L, Hot Springs, AR 71901 (501) 623-6353. Such revocation does not cover information released before the notice of revocation.

Financial Policy

As the policy holder, you understand Tri-Lakes Physical Therapy will file insurance claims on your behalf, but does require the portion not covered by your insurance company or non-covered charges to be paid by the insured. Tri-Lakes may need to contact you directly for assistance in processing insurance claims and ask you work with us in achieving this common goal.

By signing below, you authorize the direct payment for physical therapy treatment services that you have received to be made to: Tri-Lakes Physical Therapy. **Please Initial:** _____

Appointments

In the event you need to cancel or reschedule an appointment, we only ask that you contact our office at the earliest possible time to allow us to accommodate your needs. If you are unable to notify us during business hours of a schedule change, please call and leave a voicemail.

We want your experience to be the highest professional level possible. Thank you for coming to the Tri-Lakes family.

Signature of Patient or Personal Representative	Print Name & describe representative if applicable	Date