TRANSITIONS THERAPIES WEST

Aquatic and Physical Therapy

PATIENT INFORMATION SHEET/Black ink only, please.

Patient Name: _____ Date of 1st Visit: _____
Last First Middle

Date of Birth: _____ Nickname: _____ Female: _____ Male: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Patient SS#:_____ E-Mail Address: _____

Employer Information: _____
Company Name Address City, State Zip

Occupation: _____

Are you a student? Full Time: _____ Part Time: _____ School: _____

Marital Status: Married: _____ Single: _____ Divorced: _____ Widowed: ____ Spouse's Name: _____

Emergency Contact Name: _____ Relationship: _____ Phone: _____

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Primary Insurance Company: _____ Name of Insured: _____

Your Relationship to Insured: _____ Insured's DOB: _____ Insured's SS#:_____

Insured's Employer: _____ Occupation: _____

Secondary Insurance Company: _____ Name of Insured: _____

Your Relationship to Insured: _____ Insured's DOB: _____ Insured's SS#:_____

Insured's Employer: _____ Occupation: _____

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Date of Injury/Start of Symptoms: _____ Area of body to be treated: _____

Did you have surgery for this condition? No_____ Yes_____ Type: _____ Date: _____

Have you had Physical Therapy anywhere else this calendar year? _____ # of Visits: _____

Have you had Speech Therapy or Home Health Care within last 6 months? _____ # of Visits: _____

Medicare patients, have you been discharged, in writing, from Home Health Care? _____

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Is this the result of an accident? (Type):_____ Attorney Involved? Yes_____ No_____
(Home? Work? Sports? Auto?)

Attorney's Name, Address, and Phone: _____

Workers' Compensation Insurance Name: _____

Claim Number: _____ Adjustor Name: _____

Adjustor Phone: _____ Adjustor Fax: _____

PATIENT MEDICAL HISTORY

Referring Physician: _____ Ofc. Location: _____ Phone: _____

Family Physician: _____ Ofc. Location: _____ Phone: _____

How did you hear about us? _____

What conditions are you being seen for at this time?

_____

What type of symptoms are you having related to your condition? Briefly describe.

_____

What treatment have you already received? When and where? For the same condition?

_____

When is your next scheduled Doctor visit? _____

Please indicate whether you have had the following conditions (Please Circle):

1.	Allergies	YES	NO
2.	Anemia or Blood Disorders	YES	NO
3.	Asthma	YES	NO
4.	Cancer	YES	NO
5.	Congenital Abnormalities	YES	NO
6.	Diabetes	YES	NO
7.	Headaches	YES	NO
8.	Heart Disease or Heart Attack	YES	NO
9.	Hernia	YES	NO
10.	High Blood Pressure	YES	NO
11.	Incontinence	YES	NO
12.	Kidney or Bladder Problems	YES	NO
13.	Osteoporosis/Osteopenia	YES	NO
14.	Pacemaker	YES	NO
15.	Pregnancy	YES	NO
16.	Rheumatic Fever	YES	NO
17.	Pneumonia or Emphysema	YES	NO
18.	Seizures	YES	NO
19.	Stroke	YES	NO
20.	Surgical Implants (Metal)	YES	NO
21.	Tuberculosis	YES	NO
22.	Thyroid Disorders	YES	NO
23.	Other (please explain)	YES	NO

If you answered YES to any of the above conditions please explain: _____

_____

SURGERY:
Please list *all previous* operations and indicate the date/approximate age at time of procedure.

_____

_____

MEDICATION:
Please list all present medications. Please also note dosage and frequency of use. Add paper if necessary.

_____

_____

I DO HEREBY ASSIGN all insurance benefits to be paid directly to **Transitions Therapies West** for all medical services provided to me. I also acknowledge that I am personally liable for all charges incurred by me for treatment services provided to me by **Transitions Therapies West**. I further authorize **Transitions Therapies West** to release information required regarding the course of my treatment, for the purpose of evaluating and administering claims and benefits. I understand I am responsible for services not covered by my insurance, i.e. benefits exhausted or do not meet criteria of medical necessity per your plan's guidelines.

- ✓ ***YOU ARE RESPONSIBLE FOR SERVICES NOT COVERED BY YOUR INSURANCE, i.e. BENEFITS EXHAUSTED OR DOES NOT MEET THE CRITERIA OF MEDICAL NECESSITY PER YOUR PLAN. KNOW YOUR PLAN BENEFITS AND LIMITATIONS.***
- ✓ ***24-HOUR NOTICE OF CANCELLATION OR RE-SCHEDULE IS REQUIRED OR YOU WILL AUTOMATICALLY BE ASSESSED A $50.00 FEE PER OCCURRENCE.***
- ✓ ***CONTRACTUALLY, IF YOU HAVE A CO-PAYMENT, IT IS DUE AND PAYABLE PRIOR TO EACH VISIT. IF YOU HAVE CO-INSURANCE, YOU WILL BE BILLED. PAYMENT IN FULL IS DUE UPON RECEIPT OF BILL.***
- ✓ ***ANY PERSONAL BALANCE 30 DAYS OR MORE PAST DUE WILL BE SUBJECT TO A 1.5% MONTHLY FINANCE CHARGE, MINIMUM $10.00 PER MONTH.***

I HAVE BEEN INFORMED & AGREE TO ABIDE BY THE CANCELLATION AND PAYMENT POLICIES ABOVE.

X_____ _____
SIGNATURE OF PATIENT (*or PARENT, IF MINOR*) DATE

_____
PLEASE PRINT NAME IF NOT PATIENT'S SIGNATURE

I HAVE READ AND UNDERSTAND THE HIPPA COMPLIANCE INFORMATION PROVIDED TO ME.

X_____ _____
SIGNATURE OF PATIENT (*or PARENT, IF MINOR*) DATE

_____
PLEASE PRINT NAME IF NOT PATIENTS' SIGNATURE

For office use only:

Height _____ Weight _____ BMI _____

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