# Patient Information Form

Name: _____ Age: _____Date: _____

Tel: _____ Email: _____

Condition we are treating you for: _____

Onset of Symptoms: _____

Method of Injury:_____

## MEDICAL INFORMATION

- ☐ Heart Arrythmia
- ☐ A-Fib
- ☐ Pacemaker
- ☐ Any Other Heart Conditions_____
- ☐ Diabetes
- ☐ Joint Replaced_____ Date_____
- ☐ Joint Replaced_____ Date_____
- ☐ Joint Replaced_____ Date_____
- ☐ Back surgery/Type _____ Hardware yes / no
  Surgery Date_____
- ☐ Cancer/Type_____
  Surgery Date_____ Currently under treatment? Yes / no
- ☐ Arthritis
- ☐ OTHER_____
  _____

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# ACTIVITIES PRIOR TO CONDITION

**WORK** Position:_____

Please describe activity_____

**VOLUNTEER**
Position:_____

Please describe activity_____

**HOBBIES**_____

Please describe activity_____

**SPORTS** _____

How often? _____

# CURRENT ACTIVITIES

**WORK** Position: _____

Please describe activity_____

**VOLUNTEER**
Position:_____

Please describe activity_____

**HOBBIES**_____

Please describe activity_____

**SPORTS** _____

How often? _____

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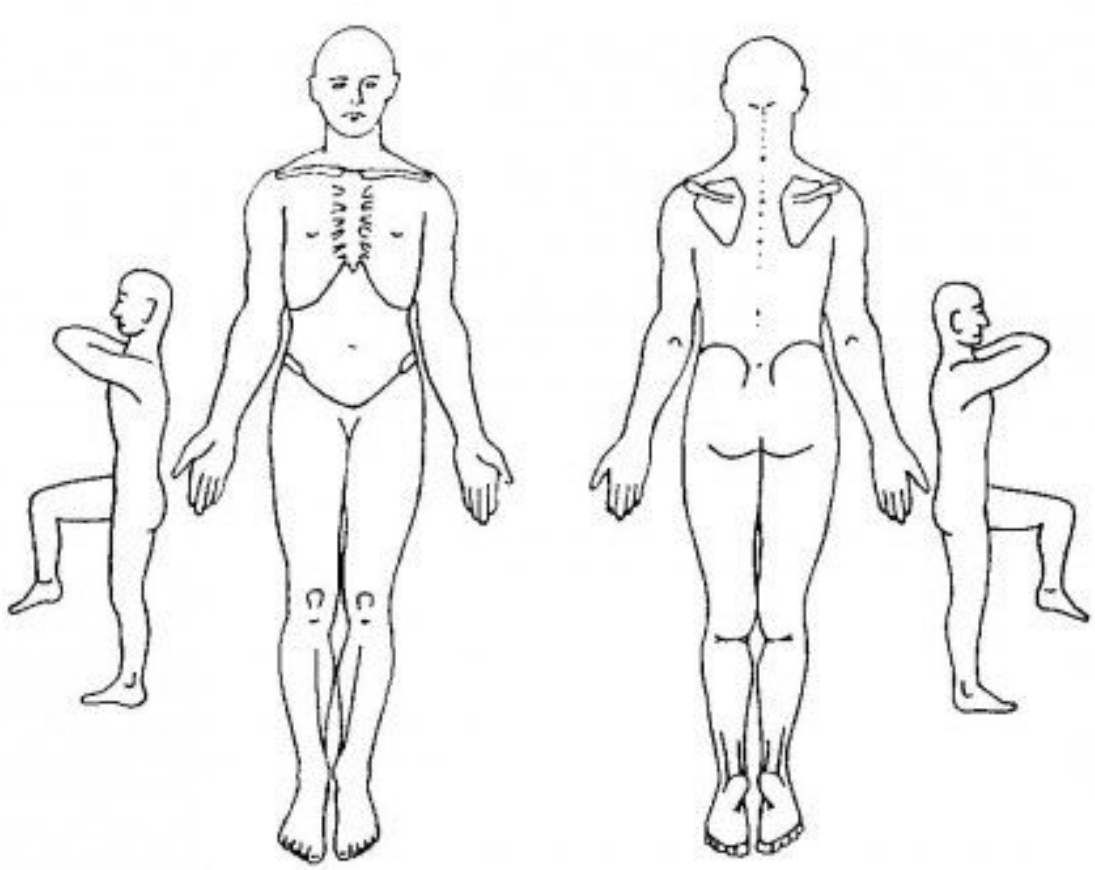
# PAIN LOCATION



PAIN LEVEL

When best 0 1 2 3 4 5 6 7 8 9 10

What makes it better?_____

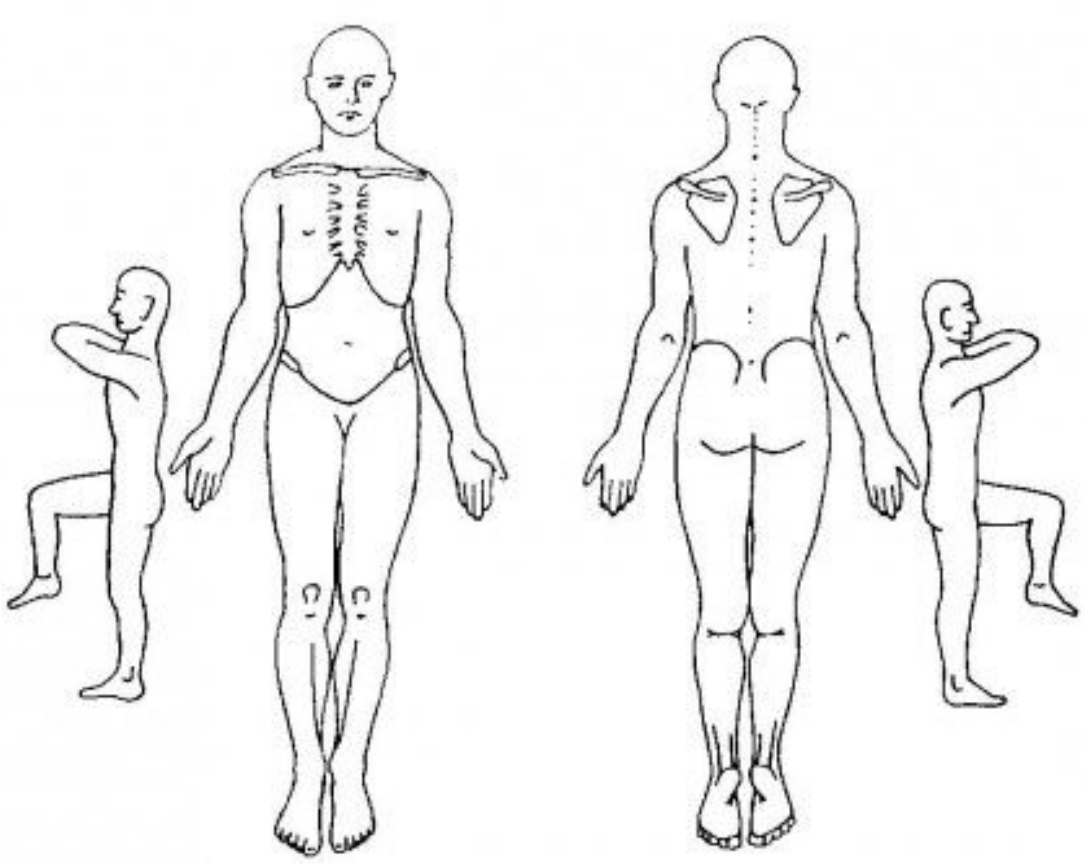
When worse 0 1 2 3 4 5 6 7 8 9 10

What makes it worse?_____

Pain is affecting you in a way that you cannot_____

_____

WEAKNESS LOCATION



WEAKNESS LEVEL

0 1 2 3 4 5 6 7 8 9 10

**THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.**

I authorize treatment, and agree to allow PT Management Solutions to file claims to the insurance company on my behalf. PT Management Solutions will file claims to insurance accordingly, however, if payment is not received within 60 days, the balance will be my responsibility (Workman Comp and Auto Insurance with LOP are exempt). **It is my responsibility to know and understand my insurance benefits. This includes deductibles, participating providers, limitations on payments, number of visits, co-pays and co-insurance information. Any balance not paid by my insurance is my responsibility.** If the insurance company reimburses me for services provided by PT Management Solutions, it is my responsibility to sign over check to "PT Management Solutions": and send to its office along with payment statement.

I also am authorizing the release of any information on my treatment that may be required to process my claim to any insurance company, attorney and/or physician.

***Please respect your appointment time. If you are unable to make it, please notify us 24 hours in advance. A $50 fee will be charged for NO SHOWS. Thank you.***

By signing below, I agree in all above statements regarding my insurance benefits and also, I acknowledge that I received the **NOTICE OF PRIVACY PRACTICE** and have had an opportunity to read it.

**Patient's Signature:** _____ **Date:** _____
**Policyholder**

**Claimant Signature:** _____ **Date:** _____
**If other than Policyholder**

**Parent or Legal Guardian:** _____ **Date:** _____