Live Well Physical Therapy

Patient Information

Name_____Preferred Name_____

Date of Birth _____ Age _____ Height_____ Weight _____ [ ] Male [ ] Female

Address_____

City_____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email Address _____

Martial Status [ ] Single [ ] Married [ ] Widowed [ ] Divorced

Social Security Number_____

Employer_____ Work Number _____

Referring Doctor _____ Primary Care Physician _____

Emergency Contact_____ Phone Number _____

Assignment and Release

I request that payment of Medicare, Medicaid, Liability, or private insurance benefits be made to Live Well Physical Therapy for any services provided to me by Live Well Physical Therapy. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance claim submissions.

Live Well Physical Therapy may use my health care information and may disclose such information to my insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Consent to Treat

I understand that I may have a condition requiring diagnostic procedures, physical examination, and/or medical treatment. I hearby voluntarily consent to such procedures, physical examination and such clinical treatment as deemed necessary by my health care providers. I further acknowledge that no guarantees have been made to me as to the results of treatment or examination provided at this facility.

LIVE WELL PHYSICAL THERAPY

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_____

Signature of Patient, Parent, Guardian, or Personal Representative

_____

Printed name of Patient, Parent, Guardian, or Personal Representative

_____ _____

Date Relationship to Patient

Live Well Physical Therapy

Medical History

Recent Medical History:

- What are we seeing you for?
- Have you been recently hospitalized?
- Have you been treated by any other professionals for this condition? (Chiropractor, Physical Therapist, Pain injections, and/ or massage)
- What medical tests have you done recently? (X-rays, CT Scan, MRI, blood test, ...)

Past Medical history:

- What conditions have you been diagnosed with? (Diabetes, cancer, high blood pressure, depression and /or anxiety...)
- Past injuries? (Fractures, motor vehicle accident...)
- Past surgeries?
- Have you fallen in the past year? (Year to date) ___Yes ___No
- Do you have a pacemaker, defibrillator, implanted device? ____Yes ___No
- List any medications you are currently taking. Please include dosage and frequency. (We can copy your medication list.)

How did you choose *Live Well Physical Therapy*?

__ Doctor Referral __Friend or Relative __Previous Patient __Facebook __Website __Health Fair

__Other:_____

If you are a first time patient and referred to us by a friend/relative please provide their name so we may thank them for their referral:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

As part of my health care, **Live Well Physical Therapy** creates and stores information about me. This includes records concerning my health history, symptoms, examinations, test results and plans for future care.

I understand that this information serves as a basis for my continuing care. I understand that this information is used as a means of communication among Live Well Physical Therapy's personnel, and with medical personnel outside of this practice. I understand that this information serves as a source of information for applying my diagnoses and surgical information to my bill.
I understand that this information is a way for third party insurance companies to assure that a service we billed for was actually performed.

I understand that this information can be used as a tool to assess the quality of care provided to patients. I have been provided an opportunity to review the Notice of Privacy Practices for Live Well Physical Therapy that provides a more complete review of information uses and disclosures. I understand that I have the right to review this Notice of Privacy Practices before signing this consent.

I understand that Live Well Physical Therapy may change its Notice of Privacy Practices at any time and that a current copy will be available for my inspection during regular business hours of each medical office and at the central billing office.

I understand that I have the right to request restrictions as to how my information may be disclosed to carry out treatment, payment or other healthcare operations and that Live Well Physical Therapy is not required to agree to the restrictions requested. The procedure to request restriction on information use and disclosure is contained in the Notice of Privacy Practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices of Live Well Physical Therapy and agree to the liability limitations explained therein.

Signature of patient or legal representative	Date	Relationship to Patient

Printed name of patient
Effective date April 14, 2003
Revised date September 23, 2013

LIVE WELL
PHYSICAL THERAPY

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www.livewellpt.com

No-Show/Cancellation Policy

We realize that emergencies and other scheduling conflicts arise which are sometimes unavoidable. However, advance notification allows us to fulfill other patient's scheduling needs and keeps our clinic operating at the most efficient level. Due to our one-on-one 45-60 min treatments, missed appointments are a significant inconvenience to your physical therapy, the clinic, and other patients.

1. **Patients who no show to an appointment are responsible for and will be assessed a $25 office visit charge. This charge cannot be billed to insurance and must be paid on or before the next scheduled appointment.**

2. We reserve your one-hour appointment time just for you and rarely double a time slot. We try very hard to not double-book patients so that we may provide optimum treatment outcomes for all our patients. 24-hour notice allows us to place another patient in your cancelled appointment period to receive their needed treatment. **Although we prefer 24-hour notice for cancellations, we do realize that certain situations arise and a penalty will not be assessed as long as patient contacts our office any time before their appointment.**

3. Certain accident claims adjusters expect regular attendance to physical therapy as a requirement of an approved treatment plan. If appointments are missed or cancelled on a regular basis, it could affect the status of your claim. Your treatment plan has been established by your medical practitioners to get you back to your regular activities as quickly as possible. Missing appointments hinders that process and may end up prolonging recovery.

Thank you for providing our office and our patients with this courtesy. Signing below indicates you understand and agree to the terms of this policy.

_____ _____

Signature of Patient Date

_____

Patient Name (Printed)