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FINANCIAL POLICY

- The patient should provide active proof of insurance at the onset of therapy services. We will verify eligibility and benefits with the insurance company, but the patient should be aware that insurance coverage is between the patient and the insurance carrier. It is ultimately the patient's responsibility to know the coverage provided by their insurance policy and understand that they are financially responsible for all charges, whether paid by the insurance carrier or not.

- **Co-payments, coinsurance, and any unmet deductible, as well as payment for cash services, are to be collected at the time of service.** Cash services are those not reimbursable by insurance and include, but are not limited to, consultations, functional dry needling, and functional taping.

- If payment is fully or partially denied by the patient's insurance, it is understood that the patient will be billed directly for services rendered, though we will make every effort to obtain payment from the insurance company.

- If the patient's account becomes past due, we reserve the right to contact the individual named as emergency contact, or turn the account over to a collection agency or an attorney, wherein the patient will be responsible for paying all collection/attorney costs.

- There will be a $30 fee for checks that have been returned for insufficient funds.

- We request the courtesy of 24-hour notice for cancellations or reschedules, though we do understand that, at times, circumstances are beyond one's control. If a patient no-shows three (3) times, they will be removed from the schedule and required to obtain another order for treatment from their physician in order to continue treatment.

- The patient accepts responsibility for all costs of collection including attorney fees, collection fee of 30%, and court costs.

By signing this document, the patient states that they are in agreement with the policy set forth above.

Patient Name (printed)_____ **Date** _____

Patient Signature _____

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PATIENT DATA SHEET

Please complete this form in its entirety prior to your first visit. Also, please bring your insurance information and/or cards and a list of medications to our office at your first visit. It is the patient's responsibility to notify our office of any changes to your information listed on this form.

PATIENT INFORMATION

Name _____
Last First Middle

Address _____
Street City State Zip

Phone Home _____ Work _____ Cell _____

Email _____ **Preferred Method of Contact** ☐ Home ☐ Work ☐ Cell

Date of Birth _____ **SS #** _____ ☐ Male ☐ Female

Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Other

REFERRING PHYSICIAN _____ **PRIMARY CARE PHYSICIAN** _____

Employer Name/Address _____

Emergency Contact _____ **Phone** _____
Name/Relation

THE ABOVE INFORMATION PERTAINS TO THE PATIENT ONLY.

IF A MINOR, THEN INSURED RESPONSIBLE PARTY COMPLETES THE NEXT SECTION.

RESPONSIBLE PARTY INFORMATION

Name of Person Responsible for this Account _____ **Relationship to Patient** _____
Last First

Address _____
Street City State Zip

Phone Home _____ Work _____ Cell _____

Date of Birth _____ **Employer Name/Address** _____

INSURANCE INFORMATION

ARE YOU AWARE OF YOUR BENEFITS FOR YOUR INSURANCE? ☐ Yes ☐ No

Primary Insurance Name _____ **Name of Insured** _____

Primary Insurance Policy # _____ ☐ SEE COPY OF CARD

Secondary Insurance Name _____ **Name of Insured**

Secondary Insurance Policy # _____ ☐ SEE COPY OF CARD

ACCIDENT INFORMATION

Was this injury related to an accident? ☐ Yes ☐ No

Date of Accident/Injury _____ ☐ Motor Vehicle Accident ☐ Work Related ☐ Other

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HIPAA & CONSENT

HIPAA:
By signing this form, I acknowledge that I have received a copy of the HIPAA privacy policy from Schaal Physical Therapy and Fitness Center, LLC and understand it completely.

CONSENT:
By signing this form, I agree to give my consent for Schaal Physical Therapy and Fitness Center, LLC to furnish physical therapy care and treatment considered necessary and proper in diagnosing and/or treating my physical condition.

Signature _____ **Date** _____

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PATIENT HISTORY QUESTIONNAIRE

INJURY INFORMATION

Date of Injury/Onset _____ ☐ Sudden Onset ☐ Gradual

Has this injury prevented you from working? ☐ Yes ☐ No **If yes, how long off work** _____

WORK STATUS: At present time, I am able to:

- ☐ Work without restrictions
- ☐ Work the same job with restrictions
- ☐ Work a different job with restrictions
- ☐ Unable to work due to dysfunction
- ☐ Don't normally work outside the home
- ☐ Homemaker
- ☐ Retired
- ☐ Other

Is an attorney involved with the case? ☐ Yes ☐ No

Have you sought previous treatment for this condition?

- ☐ No other treatment
- ☐ Massage Therapy
- ☐ Chiropractor
- ☐ Physical/Occupational Therapy
- ☐ Psychiatrist/Psychologist
- ☐ Other

What tests have you had for your symptoms and when were they performed?

☐ X-Rays Date: _____ ☐ MRI Date: _____ ☐ CT Scan Date: _____ ☐ Other Date: _____

Please list all prescription medication you are taking, including dosage and frequency (Including injection and patches):

_____

_____

Please list any surgeries or other conditions for which you have been hospitalized:

Date	Surgery/Hospitalization	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

SYMPTOM INFORMATION

Are you currently having or have you have you experienced any of these symptoms in the past 3 months?

- ☐ Fever
- ☐ Chills
- ☐ Night Sweats
- ☐ Shortness of Breath
- ☐ Pins/Needles
- ☐ Numbness
- ☐ Skin Rash
- ☐ Headaches
- ☐ Vision Problems
- ☐ Hearing Loss
- ☐ Bowel/Bladder Problems
- ☐ Dizziness/Fainting

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Please check all the following conditions that apply to you either presently or in the past:

☐ High Blood Pressure	☐ Epilepsy/Seizures	☐ Gout	☐ Dizziness/Fainting
☐ Chest Pain/Heart Attack	☐ Kidney Disease	☐ Hepatitis	☐ Depression
☐ Stroke	☐ Asthma	☐ Arthritis	☐ Lung Disease
☐ Heart Disease	☐ Emphysema/Bronchitis	☐ Thyroid Problems	☐ Traumatic Brain Injury
☐ Cardiovascular Disease	☐ Parkinson's	☐ Multiple Sclerosis	☐ Osteoporosis
☐ Chemical Dependency (alcohol/drugs)	☐ Rheumatoid Arthritis	☐ Alzheimer's/Dementia	☐ Cancer
☐ Fibromyalgia	☐ Diabetes	☐ Varicose Veins	

☐ Emotional/ Psychological Problems - Please Explain: _____

☐ Allergies: _____

☐ Other: _____

Do you have a pacemaker? ☐ Yes ☐ No

DISCOMFORT INFORMATION

Please rate your average discomfort on the scale below:

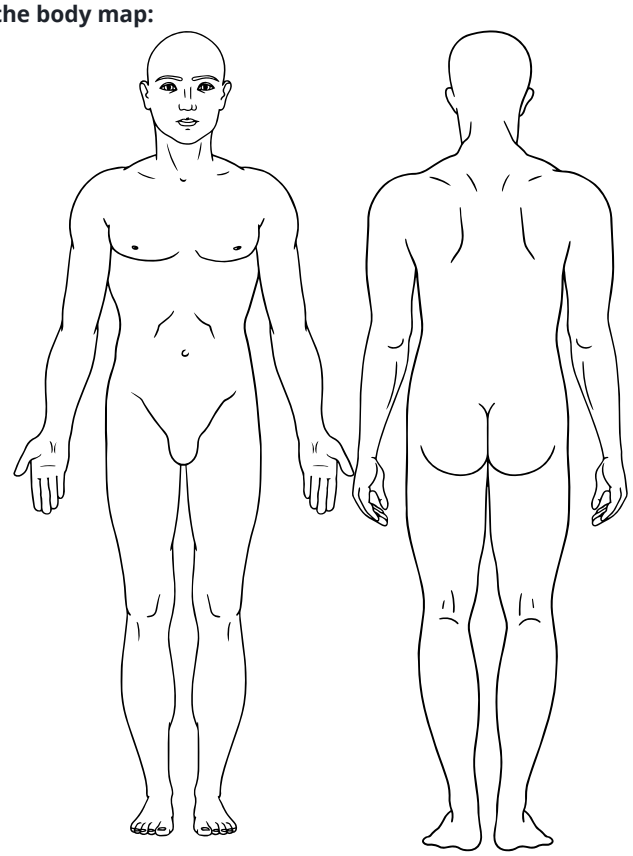
0 _____ 10
(no pain) (severe pain)

Please map your areas of discomfort or altered sensation on the body map:

XXX= Pain

000= Numbness

***= Weakness



Other comments you may have:

_____

_____

_____

_____

_____