

First Name:	Middle:	Last:
Preferred Name:		
Address:		City/State:
Zip Code:	Date of Birth:	SSN:
Home Phone <input type="checkbox"/> : ( ) Mobile <input type="checkbox"/> : ( ) Work <input type="checkbox"/> : ( ) ****Please check which phone number we can leave a voice message regarding treatment dates and times****		
E-mail address:		

What sex were you assigned at birth?  Male  Female

What is your gender?  Man  Woman  Other \_\_\_\_\_

Employer:	Occupation	
Emergency Contact:	Relationship:	Phone: ( )
Health Insurance Name(s): Primary:		Secondary:
Subscriber Name:	DOB:	Relationship:
Primary Care Physician:	Practice:	City/State:
Referred by: Practice:		City/State:
Reason for Today's Visit:		Date of Injury/Surgery:
Have you had previous P.T. for this injury? Y / N		Dates of service:
Where did you go for treatment?		How many visits?

<b>Is this a Workers' Compensation Claim? Y / N</b>	Claim Number:
Workers' Compensation Insurance Company:	
Employer:	Employer Contact Person Phone Number:
<b>Is this an Automobile Insurance Claim? Y / N</b>	State Accident Occurred
Party Responsible for Payment:	
Automobile Insurance Company:	Claim Number:
<b>Attorney involved? Y / N Name:</b>	Phone Number:

How did you hear about us?  Friend  Physician  Radio  Web  Newspaper  Drove by Other:

## Medical Information

<p style="text-align: center;"><b>Past History (please circle)</b></p> <p>Asthma COPD Pulmonary Disease High Blood Pressure High Cholesterol Vascular Disease Arrhythmia Palpitations Heart Attack Pacemaker Stroke          Other Cardiac Disease _____          Diabetes Type 1 / Type 2 Hypoglycemia          Cancer (please specify) _____ Depression          Anxiety Seizures Osteoporosis Osteopenia          Fractures (please specify) _____          Pregnancies/Births _____ C-Sections ____          Injuries (please specify) _____</p> <p>_____</p> <p>Allergies (please specify) _____</p> <p>_____</p> <p>Surgeries (please specify) _____</p> <p>_____</p> <p>_____</p> <p>Other _____</p> <p>_____</p> <p>_____</p>	<p style="text-align: center;"><b>Medications</b></p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">Name</th> <th style="width: 20%;">Dosage</th> <th style="width: 20%;">Frequency</th> <th style="width: 30%;">Route</th> </tr> </thead> <tbody> <tr><td>_____</td><td></td><td></td><td></td></tr> <tr><td>_____</td><td></td><td></td><td></td></tr> <tr><td>_____</td><td></td><td></td><td></td></tr> <tr><td>_____</td><td></td><td></td><td></td></tr> <tr><td>_____</td><td></td><td></td><td></td></tr> </tbody> </table> <p style="text-align: center;"><b>Family History</b></p> <p>Cancer Cardiovascular Disease Diabetes</p> <p style="text-align: center;"><b>Currently, are you or do you have:</b></p> <p>Pregnant Chest Pain Infection HIV TB Hepatitis          Light Headedness Dizziness Fatigue Loss of Consciousness Swelling Fever Night Sweats          Weakness Numbness Tingling Shortness of Breath          Loss of Bowel or Bladder Control Night Pain          Recent Weight Gain or Loss (more than normal)</p> <p><b>Do You Use Tobacco Products? Yes No</b> How much per day? _____ How long? _____</p> <p style="text-align: center;"><b>Rate Your Quality of Health</b></p> <p style="text-align: center;">Poor Fair Good Excellent</p>	Name	Dosage	Frequency	Route	_____				_____				_____				_____				_____			
Name	Dosage	Frequency	Route																						
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Please use the diagram below to indicate the symptoms you have experienced today.

**Key:**

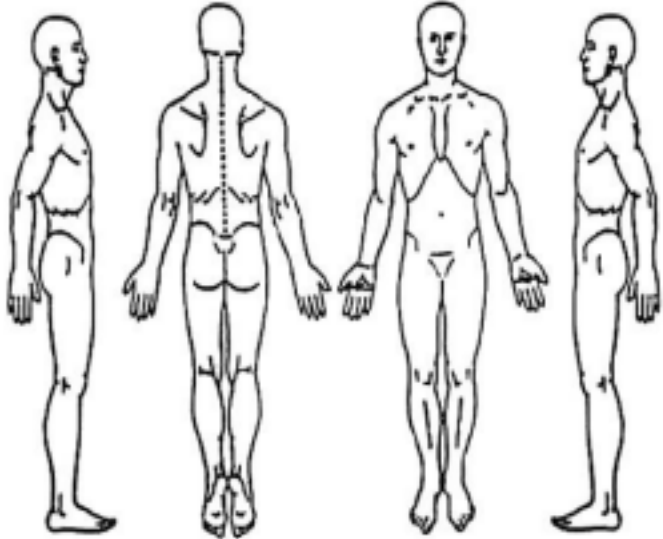
Pins/Needles=OOO

Burning = X X X

Stabbing = / / /

Numbness = N N N

Deep Ache = Z Z Z





**By signing below I am acknowledging and agreeing to the following:**

**CONSENT TO EXAMINATION AND TREATMENT:** I consent to examination and/or treatment by the physical therapist, assistant, aide, medical technician and/or student of me or the minor patient listed below. This may include, but not be limited to exercise, hands on treatment, or use of medical tools and devices whose purpose will be explained prior to use. I understand that the provider will take into consideration my/minor patient's conditions and use his or her best judgment for my/minor patient's safety to help achieve the goals for the treatment. I understand that I may stop my request for treatment before any procedure or test.

**CANCELLATION POLICY:** We, at Coppola Physical Therapy, will make every effort to schedule your therapy appointments at a time that is convenient for you. In the event that you cannot attend a particular scheduled appointment, **we ask that you call Coppola Physical Therapy at least 24 hours prior to that appointment to cancel and/or reschedule that appointment. If you do not call to cancel or do not show for a scheduled appointment, you could be charged a \$50 fee for a missed appointment.**

If you miss 3 scheduled appointments, we reserve the right to discharge you from therapy. In order to resume therapy after such time you will need to see your physician, obtain another prescription and call us to schedule a re-evaluation.

Also, if you are more than 15 minutes late for your appointment, it will be left to the discretion of your therapist whether or not you will be treated at that time.

I give permission for Coppola Physical Therapy to contact me at home or at my work for any therapy/insurance related issue.

If you have any questions about this policy, please do not hesitate to ask. Thank you advance for your cooperation.

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Signature of patient	Name of Patient (please print)	Date
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Parent/Guardian Signature	Name of Parent/Guardian	Date
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**BILLING AND PAYMENT:** If I/minor patient has health insurance coverage, I agree to assign the insurance benefits to Coppola Physical Therapy for payment of the services and supplies provided to me/minor patient.

I understand that Coppola Physical Therapy will:

- Bill my/minor patient's primary and secondary insurance companies for the treatment and supplies provided.
- **I agree to pay Coppola Physical Therapy for the balance of any charges not covered by insurance (this includes any deductible, co-payments and coinsurance), for the full amount of the bill for any services that I receive not covered by my insurance(s), in the event of a workers' compensation denial, and regardless of any ongoing legal cases related to my reason for attending physical therapy.**
- **It is Coppola Physical Therapy's policy to store credit card information on file. Please inform our Office Staff, should you wish your credit card information to be removed.**
- I understand that it is my responsibility to obtain any preauthorization or referral required by my insurance carrier.
- **It is Coppola Physical Therapy's policy to collect \$50 towards your deductible at time of service; the remainder of balance will be due once your insurance carrier processes the claims.** • I understand I will be charged a \$25.00 fee for any and all checks returned from the bank for insufficient funds.

**MEDICARE or MEDICAID BENEFICIARIES:**

- If I am a Medicare or Medicaid beneficiary, I will only be billed for any deductibles, coinsurance, and for services or items provided to me that are not covered by Medicare or Medicaid. • I certify that the information given by me for payment under Medicare (Title XVIII of the Social Security Act) and/or Medicaid (Title XIX of the Social Security Act) is correct.

**NOTICE OF PRIVACY PRACTICES:** I acknowledge that I have received Coppola Physical Therapy's Notice of Privacy Practices, and if I wish to obtain another copy, one shall be provided to me.

**NO GUARANTEE OF OUTCOME:** I understand that no guarantees have been made to me about the outcomes of my treatment.

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Signature of patient	Name of Patient (please print)	Date
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Parent/Guardian Signature	Name of Parent/Guardian	Date
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## SMS Communication Authorization

By signing below, I authorize Coppola Physical Therapy & Fitness Gym to send me text messages for appointment confirmations, scheduling changes, treatment instructions, billing notifications, insurance updates, and general clinic communication.

- Message frequency varies
- Message & data rates may apply
- Consent is not required as a condition of receiving treatment
- I may opt out at any time by replying STOP
- Information will not be given to a third party

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Signature of patient

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Name of Patient (please print)

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Date

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Parent/Guardian Signature

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Name of Parent/Guardian

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Date