PATIENT 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 and 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 or not paid by the insurance carrier.

- **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 required to obtain another order for treatment from their physician in order to continue with 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: _____

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 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 way to contact you □Home □Work □Cell

Date of Birth:_____ Social Security Number: _____ □Male □ Female
□ Married □ Single □ 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 THE PATIENT IS A MINOR, THEN THE RESPONSIBLE PARTY COMPLETES THE NEXT SECTION.

RESPONSIBLE PARTY INFORMATION Relation to the Patient □Mother □ Father □ Other_____

Name: _____Date of Birth: _____
Last First

Address:_____
Street City State Zip

Phone: Home ( )_____ Work ( )_____ Cell ( )_____

Employer
Name/Address:_____

INSURANCE INFORMATION **ARE YOU AWARE OF YOUR BENEFITS FOR YOUR INSURANCE? □YES □NO**

Primary Insurance Name:_____ Insured Name:_____

Primary Insurance Policy #:_____ □SEE COPY OF CARD

Secondary Insurance Name:_____ Insured Name:_____

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_____

(see back side)

HIPPA: By signing this form I acknowledge that a copy of the HIPPA "Notice of Information Practices" from Schaal Physical Therapy and Fitness Center, LLC was available to me and I 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

SCHAAL PHYSICAL THERAPY AND FITNESS CENTER, LLC
PATIENT HISTORY QUESTIONNAIRE

PLEASE FILL OUT THIS FORM AS COMPLETE AS POSSIBLE. IT WILL ASSIST YOUR THERAPIST IN DEVELOPING A PLAN OF CARE FOR YOU. IF YOU HAVE ANY QUESTIONS, PLEASE FEEL FREE TO ASK FOR ASSISTANCE. THIS INFORMATION WILL REMAIN CONFIDENTIAL UNLESS AUTHORIZED FOR RELEASE BY THE PATIENT.

NAME_____ DATE OF BIRTH_____

ADDRESS_____ PHONE NUMBER_____

OCCUPATION _____ HOBBIES _____

DATE OF INJURY/ONSET_____ PLEASE CIRCLE: SUDDEN ONSET GRADUAL ONSET

HAS THIS INJURY PREVENTED YOU FROM WORKING? YES NO IF YES, HOW LONG OFF WORK _____

WORK STATUS: AT THE **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

IF YES, ATTORNEY NAME: _____ PHONE: _____

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?

__ Xrays date:_____ __ MRI date:_____ __ CT SCAN date:_____ __ OTHER date:_____

HAVE YOU HAD SIMILAR SYMPTOMS IN THE PAST? If you have received treatment in the past for the same or similar symptoms, who did you see?

__ This office __ Other Chiropractor __ Medical Doctor __ Physical Therapist __ Other

LIST ALL PRESCRIPTION MEDICATION YOU ARE TAKING WITH DOSAGE AND FREQUENCY (Including injection and skin patches):_____

_____

_____

PLEASE LIST ANY SURGERIES OR OTHER CONDITIONS FOR WHICH YOU HAVE BEEN HOSPITALIZED:

DATE	SURGERY/HOSPITALIZATION	REASON
_____	_____	_____
_____	_____	_____

ARE YOU CURRENTLY HAVING OR 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

PLEASE CHECK ALL THE FOLLOWING CONDITIONS THAT APPLY TO YOU EITHER PRESENTLY OR IN THE PAST

___ High Blood Pressure ___ Epilepsy/Seizures ___ Gout ___ Varicose Veins
___ Chest Pain/Heart Attack ___ Kidney Disease ___ Hepatitis ___ Dizziness/Fainting
___ Stroke ___ Asthma ___ Arthritis ___ Depression
___ Heart Disease ___ Emphysema/Bronchitis ___ Lung Disease
___ Cardiovascular Disease ___ Parkinson's ___ Thyroid Problems
___ Chemical Dependency (alcohol/drugs) ___Multiple Sclerosis
___Fibromyalgia ___Rheumatoid Arthritis ___Traumatic Brain Injury
___Cancer ___Diabetes ___Alzheimer's ___ Osteoporosis
___ Emotional/Psychological Problems-Explain_____
___Allergies:_____
___ Other: _____

Do you have a pacemaker? Yes No

HAS ANYONE IN YOUR IMMEDIATE FAMILY (Parents, Brothers, Sisters) EVER BEEN TREATED FOR ANY OF THE FOLLOWING?

___ Cancer ___ Heart Disease ___ Diabetes ___ Tuberculosis __Mental Disorder
___ Arthritis ___ High Blood Pressure ___ Kidney Disease ___ Stroke

HAVE YOU RECENTLY EXPERIENCED ANY SIGNIFICANT CHANGES IN:

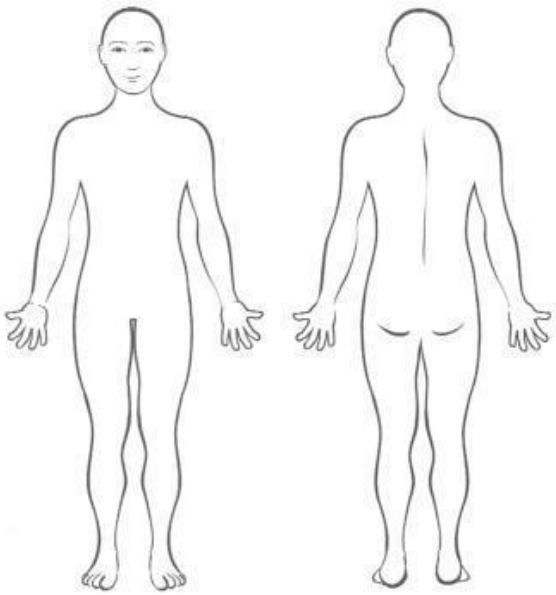
___ Mood ___ Energy level (restlessness, lethargy, or fatigue)
___ Interest or pleasure in daily activities ___ Recurrent thoughts of death or harming yourself
___ Loss/Gain of appetite or weight loss/gain ___ Sleeping habits

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=Numb/Tingle ***= Weakness



OTHER COMMENTS OR CONCERNS YOU MAY HAVE:

_____

_____

_____