PT-OT Professionals
Physical-Occupational Therapy

APPOINTMENT INFORMATION

Who recommended PT-OT Professionals for your care (circle):

Doctor / Self / Friend / Return / Advertising: _____ Other: _____

Date of Accident/Injury: ___/___/_____ OR Date Symptoms Began: ___/____/____

Type of Accident: ☐ at work ☐ at home ☐ auto ☐ other (explain): _____

Name(s) of family, friends, or others we may communicate with regarding your treatment, appointments, prescriptions, test results, billing, and insurance questions, etc:

_____

PATIENT INFORMATION

Name: (Last) _____ (First) _____ (M.I.) _____ Sex: ☐ M ☐ F

Address: _____ City: _____ State: _____ ZIP: _____

Date of Birth: ____/_____/_____ Social Security Number: _____-____-_____ Marital Status: _____

Home Phone # _____ Cell Phone # _____ Email: _____

Employer: _____ Work Phone: _____

Spouse's Name: _____ Employer: _____

Work Phone: _____ Cell Phone: _____

Emergency Contact Person: _____ Relationship: _____

Home Phone # _____ Cell Phone # _____

Appointment Reminders: ☐ Text ☐ Email

AUTHORIZATION AND CONSENT

I hereby consent to medical treatment, including evaluation, diagnosis, treatment or care, as ordered by my physician or other licensed provider for myself, or for the patient for whom I am the parent or authorized representative. I acknowledge that no guarantees or promises have been made concerning the results of any procedure or treatment I receive.

I hereby authorize PT-OT Professionals to disclose my protected health information and/or other information to treat me, for requests by other health care providers involved in my continued or future treatment, to determine benefits, to authorize payment, and to process claims for payment. I further authorize any insurance company, organization, employer, hospital, physician, dentist, or pharmacist to release any information required to process my claim(s) or to provide continued or future treatment.

I authorize payment of benefits on my behalf by my insurance plan or any government sponsored plan directly to PT-OT Professionals. I understand that if the providers at PT-OT Professionals are not participating providers with my insurance plan, I am responsible for amounts determined ineligible by my insurance plan. I agree to pay any copays, deductible, or co-insurances that are my responsibility under my insurance plan(s) at the time of service. I understand that I will be billed and held responsible for my account regardless of the status of any insurance claim(s). Interest charges of 1.5% per month will be charged on all outstanding patient balances over 90 days.

For Worker's Compensation injury claims, signing below authorizes PT-OT Professionals to bill my Worker's Compensation insurance for my claims. In the unlikely event that my injury is determined not to be work-related, any unpaid bills will become my responsibility. In have read, had my questions answered, and agree to comply with this statement.

Signed: _____ Date: _____ / _____ / _____

PT-OT Professionals, Inc.
Authorization for Appointment Reminders

As required by the Health Insurance Probability and Accountability Act of 1996, PT-OT Professionals, Inc. may not use or disclose your personal health information except as provided in our Notice of Privacy Practices (which you have received and been provided an opportunity to review) without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures described herein.

I hereby authorize PT-OT Professionals, Inc. to call my residence for the purpose of reminding me of my appointment, or to schedule a new appointment with one of PT-OT Professional's providers.

In case I am not available, I also authorize PT-OT Professionals, Inc. to communicate the reminder by leaving a message with the person who answers the phone call or on my answering machine/voice mail.

I understand the message will identify the call as coming from PT-OT Professionals and will include the date and time of my appointment. If necessary, the message will also include special instructions regarding my appointment.

_____	_____	_____	_____
Patient Name (Printed)	Date of Birth	Patient Signature	Date

Medical History

Existing or Relevant Previous Conditions

Allergies	☐Yes ☐ No	Dizzy Spells	☐Yes ☐ No	MRSA	☐Yes ☐ No
Anemia	☐Yes ☐ No	Emphysema/Bronchitis	☐Yes ☐ No	Multiple Sclerosis	☐Yes ☐ No
Anxiety	☐Yes ☐ No	Fibromyalgia	☐Yes ☐ No	Muscular Disease	☐Yes ☐ No
Arthritis	☐Yes ☐ No	Fractures	☐Yes ☐ No	Osteoporosis	☐Yes ☐ No
Asthma	☐Yes ☐ No	Gallbladder Problems	☐Yes ☐ No	Parkinsons	☐Yes ☐ No
Autoimmune Disorder	☐Yes ☐ No	Headaches	☐Yes ☐ No	Rheumatoid Arthritis	☐Yes ☐ No
Cancer	☐Yes ☐ No	Hearing Impairment	☐Yes ☐ No	Seizures	☐Yes ☐ No
Cardiac Conditions	☐Yes ☐ No	Hepatitis	☐Yes ☐ No	Smoking	☐Yes ☐ No
Cardiac Pacemaker	☐Yes ☐ No	High Cholesterol	☐Yes ☐ No	Speech Problems	☐Yes ☐ No
Chemical Dependency	☐Yes ☐ No	High/Low Blood Pressure	☐Yes ☐ No	Strokes	☐Yes ☐ No
Circulation Problems	☐Yes ☐ No	HIV/AIDS	☐Yes ☐ No	Thyroid Disease	☐Yes ☐ No
Currently Pregnant	☐Yes ☐ No	Incontinence	☐Yes ☐ No	Tuberculosis	☐Yes ☐ No
Depression	☐Yes ☐ No	Kidney Problems	☐Yes ☐ No	Vision Problems	☐Yes ☐ No
Diabetes	☐Yes ☐ No	Metal Implants	☐Yes ☐ No		

Describe any other conditions

If "Yes" to any of the above, please explain and give approximate dates/describe any other conditions

Fall History

Injury as a result of a fall in the past year? ☐ Yes ☐ No ☐ N/A
Two or more falls in the last year? ☐ Yes ☐ No ☐ N/A

Surgical History

Body Region: _____ Surgery Type _____ Date(s): _____

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Body Region: _____ Surgery Type _____ Date(s): _____

Body Region: _____ Surgery Type _____ Date(s): _____

Current Medications

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

☐ Currently not taking any medications