



Initial	Please read the following closely and initial when finished.
X _____ Initial	<b>Cancellation/No Show Policy:</b> Union Physical Therapy has a 24 hour cancellation / rescheduling policy. If you miss your appointment, cancel, or change your appointment with less than 24 business hours notice, you will be charged \$50. If you no-show or late cancel for 2 or more visits Union PT reserves the right to discharge you from our care. This policy is in place out of respect for our therapists and our clients. Cancellations with less than 24 hours notice are difficult to fill, preventing someone else from being able to schedule and attend that appointment.
X _____ Initial	<b>Credit/Debit Card Acceptance:</b> Union Physical Therapy will impose a surcharge of 3.5% on the transaction amount for debit and credit card payments, which is not greater than our cost of acceptance. This fee does not apply to individuals using a debit card linked to an HSA account. If you would like to avoid this fee please pay your account balance using a check or cash.
X _____ Initial	<b>Financial Policy:</b> I understand billing my insurance is a courtesy provided to me from Union Physical Therapy at no additional cost, and does not relieve my financial responsibility. I agree that Union Physical Therapy may furnish the responsible insurance company, and other authorized parties, with necessary information to process physical therapy claims on my behalf in a timely manner. Co-payments are due at check-in prior to seeing the therapist. If you schedule more than one visit in a week, you may pay in advance for the entire week's co-pays. If you are responsible for a quoted percentage or you have a deductible that has not been met, you will be informed of this. In the event that my pending claim is denied, I understand that I am fully responsible and agree to pay Union Physical Therapy for all the costs associated with my treatment. Payment can be made by either cash, check, HSA or FSA card. I understand my insurance may have specific limits or restrictions for physical therapy/rehabilitation services and it is my responsibility to be aware and to monitor these limits. I understand I am responsible for all deductibles, co-pays and services not covered by my insurance carrier. Most insurance companies have a contracted rate of reimbursement for physical therapy plus a co-payment or patient payment responsibility. Each insurance or third party payer is different and benefits vary. We will attempt to contact your company prior to providing services, so that you have an estimate of your benefit coverage. This estimate is not a guarantee of your benefit coverage. For self-pay patients payment is due at the time of service. A discount will be applied for payment in full on the day of the appointment.
X _____ Initial	<b>SMS/Text Messaging Consent:</b> I authorize Union Physical Therapy and their staff to send me text reminders of my appointments and future openings from my therapist's waitlist. Regular messaging and data fees apply per the details of my wireless data plan.
X _____ Initial	<b>HIPAA/Consent to Treat/Informed Consent:</b> HIPAA: By signing this form I acknowledge that I have received a copy of the HIPAA "Notice of Information Practices" from Union Physical Therapy, LLC and understand it completely.  CONSENT: By signing this form, I agree that I have read and understand the <i>Informed Consent for Physical Therapy Treatment</i> form and give my consent to Union Physical Therapy, LLC to furnish physical therapy care and treatment considered necessary and proper in diagnosing and/or treating my physical condition.

Printed Name:

Signature:

Date:

Medicare is not my primary health insurance



(Please Print)

Today's date:		PCP:	
<b>PATIENT INFORMATION</b>			
Patient's last name:		First:	MI:
			Birthdate:
Street address:		City:	State: Zip Code:
Marital status (circle one) Single / Married / Other	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Cell phone no: <input type="checkbox"/> Preferred (    )	Home/Alt. phone no.: <input type="checkbox"/> Preferred (    )
	Preferred Pronouns:		
Email address:		Employer:	
Referring provider:	Address:		Phone no.: (    )
<b>INSURANCE INFORMATION</b>			
(Please provide a copy of your insurance card.)			
Primary Insurance:		ID #:	Group #:
Subscriber's name:	Birthdate: / /	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Phone no.: (    )
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			
Customer service phone no.: (    )	Insurance billing address:		Employer:
Name of secondary insurance (if applicable):		ID #:	Group #:
Subscriber's name:	Birthdate: / /	Insurance billing address:	Customer service phone no.: (    )
	Sex: <input type="checkbox"/> M <input type="checkbox"/> F		
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			
<b>IF ACCIDENT RELATED:</b>			
Date of accident:		How it happened: <input type="checkbox"/> Work <input type="checkbox"/> Auto <input type="checkbox"/> Other _____	
Insurance company:		Claim #:	
Address:			
Claims adjuster:		Phone no:	
Attorney:		Phone no:	
<b>IN CASE OF EMERGENCY</b>			
Name of local friend or relative:		Relationship to patient:	Primary phone no.: (    )
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Union Physical Therapy, LLC or insurance company to release any information required to process my claims.			
_____ <i>Patient/Guardian signature</i>		_____ <i>Date</i>	

Patient Name: \_\_\_\_\_ DOB \_\_\_\_\_ Date: \_\_\_\_\_

Are you DNR (do not resuscitate)? If yes, please provide copy of DNR or advance directives. \_\_\_\_\_

What condition are you here to address? \_\_\_\_\_

When did symptoms begin? \_\_\_\_\_

How did symptoms begin? \_\_\_\_\_

What activity makes symptoms worse? \_\_\_\_\_

What makes symptoms better? \_\_\_\_\_

Have you received prior treatment for this condition? If so, where, when and how much? \_\_\_\_\_

**Past Surgeries:**

1. \_\_\_\_\_ Date: \_\_\_\_\_

2. \_\_\_\_\_ Date: \_\_\_\_\_

**Have you received any imaging (X-ray, MRI, CT, ultrasound, etc):**

1. \_\_\_\_\_ Date: \_\_\_\_\_

2. \_\_\_\_\_ Date: \_\_\_\_\_

**Medical History (Check all that apply):**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Allergies (latex)               | <input type="checkbox"/> Chest Pain                                   | <input type="checkbox"/> Use of tobacco/<br>packs per week _____ |
| <input type="checkbox"/> Rheumatoid<br>disease/Arthritis | <input type="checkbox"/> Headaches                                    | <input type="checkbox"/> HIV+/AIDS                               |
| <input type="checkbox"/> Osteoarthritis                  | <input type="checkbox"/> MVC (Motor Vehicle<br>Collision) Date: _____ | <input type="checkbox"/> Wear Orthotics                          |
| <input type="checkbox"/> Osteoporosis/<br>Osteopenia     | <input type="checkbox"/> Polio  | <input type="checkbox"/> Multiple Sclerosis                      |
| <input type="checkbox"/> Asthma                          | <input type="checkbox"/> Broken Bones                                 | <input type="checkbox"/> Diabetes                                |
| <input type="checkbox"/> Depression                      | <input type="checkbox"/> Tuberculosis                                 | <input type="checkbox"/> Pacemaker                               |
| <input type="checkbox"/> High Blood Pressure             | <input type="checkbox"/> Joint Replacement                            | <input type="checkbox"/> Cancer                                  |
| <input type="checkbox"/> Anemia                          | <input type="checkbox"/> Thyroid Problems                             | <input type="checkbox"/> Back/Neck pain                          |
| <input type="checkbox"/> Major<br>Illness/Accident       | <input type="checkbox"/> Stroke                                       | <input type="checkbox"/> Hepatitis                               |
| <input type="checkbox"/> Cystic Fibrosis                 | <input type="checkbox"/> Seizures                                     | <input type="checkbox"/> Cardiac Condition                       |
| <input type="checkbox"/> Migraines                       | <input type="checkbox"/> Lung Disease                                 | <input type="checkbox"/> Pneumothorax                            |
|  | <input type="checkbox"/> Shortness of breath                          |  |

Do you currently have any of the following? (Check all that apply):

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Nausea/Vomiting            | <input type="checkbox"/> Bowel/Bladder changes | <input type="checkbox"/> Recent Fall       |
| <input type="checkbox"/> Fever/Chills/Sweats        | <input type="checkbox"/> Skin Rash             | <input type="checkbox"/> Balance Problems  |
| <input type="checkbox"/> Unexplained weight change  | <input type="checkbox"/> Dizziness             | <input type="checkbox"/> Vision Changes    |
| <input type="checkbox"/> Numbness/Tingling Location | <input type="checkbox"/> Headaches             | <input type="checkbox"/> Possibly Pregnant |
|   | <input type="checkbox"/> Muscle Weakness       |  |

Medications (Check all that apply and list the dosage you currently take):

- Steroids \_\_\_\_\_
- Anti-inflammatory \_\_\_\_\_
- Pain Killers \_\_\_\_\_
- Heart Medication \_\_\_\_\_
- Blood Pressure Medication \_\_\_\_\_
- Anti-coagulants (blood thinners) \_\_\_\_\_
- Muscle Relaxants \_\_\_\_\_
- Insulin (diabetes)
- Diuretic (water pill)
- Over the counter medication (Tylenol etc.)
- Supplements/vitamins \_\_\_\_\_

How many hours of sleep do you get each night? \_\_\_\_\_

Rate your pain at best and worst below

0 10  
 (No Pain) (Severe Pain)

Frequency of your pain (circle one)

0-25%    26-50%    51-75%    76-100%

If you have dizziness rate at best and worst below

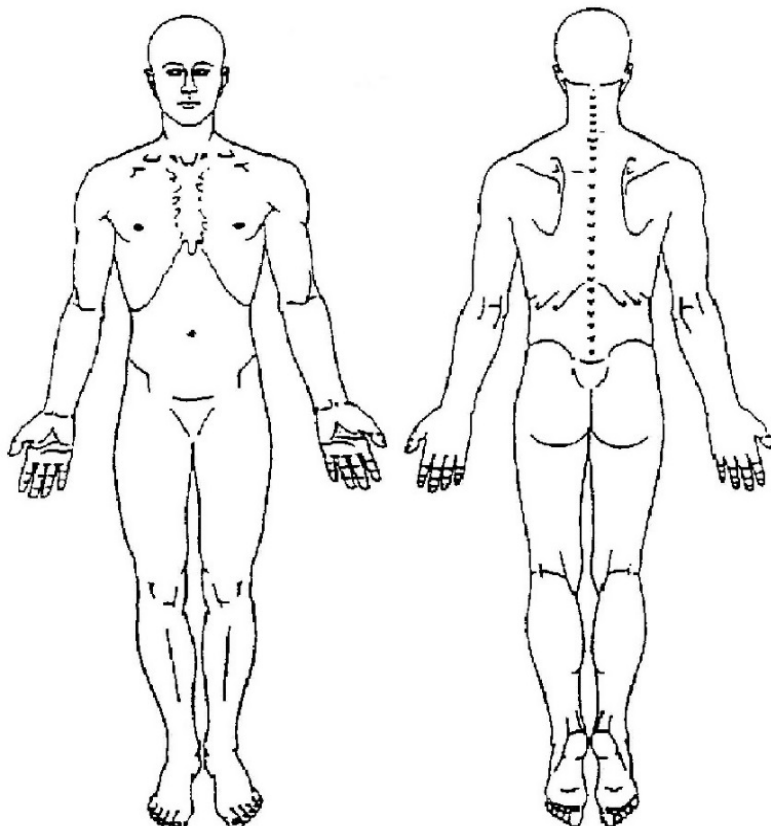
0 10

Please map your areas of discomfort or altered sensation in the last 7 days on the body map

XXX=Pain    000=Numb/Tingle    ●●●=Weakness

Signature: \_\_\_\_\_

Date: \_\_\_\_\_





Name: \_\_\_\_\_ Date: \_\_\_\_\_

## The Patient-Specific Functional Scale

This useful questionnaire can be used to quantify activity limitations and measures functional outcomes for patients with any orthopedic condition.

Please identify up to three activities that pertain to basic daily living tasks or work functions that you are unable to do or are having difficulty with as a result of your condition. Then rate each activity based on the scale below. Please complete the optional health and wellness-specific questionnaire if applicable.

### Patient-Specific Activity Scoring

	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>
	Unable to perform activity										Able to perform activity at the same level as before injury or problem

### Basic Daily Living Tasks and Work Functions

Activity	Score
<i>(Ex. Working at a computer, bending forward, etc)</i>	
1.	
2.	
3.	

### Health and Wellness Activities (optional)

Activity	Score
<i>(Ex. Rock climbing, mountain biking, etc)</i>	
1.	
2.	
3.	