Initial	Please read the following closely and initial when finished.
X______ Initial	**Cancellation/No Show Policy:** 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 $100. 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	**Financial Policy:** 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	**SMS/Text Messaging Consent:** I authorize Union Physical Therapy and their staff to send me text reminders of my appointments, future openings from my therapist's waitlist and my account balance. Regular messaging and data fees apply per the details of my cellular plan.
X_____ Initial	**HIPAA/Consent to Treat/Informed Consent:** 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 *Informed Consent for Physical Therapy Treatment* 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.
X_____ Initial	**I am notifying Union Physical Therapy staff of my vaccination status. By signing to the left, I denote that I received full vaccination for COVID-19 at the time of my first appointment.**

____

Printed Name:

____

Signature:

____

Date:

☐ Medicare is not my primary health insurance

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(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	MI:	Birthdate:
Street address:	City:	State:	Zip Code:
Marital status (circle one) Single / Married / Other	Sex: ❑ Male ❑ Female Preferred Pronouns:	Cell phone no: ❑ Preferred ( )	Home/Alt. phone no.: ❑ Preferred ( )
Email address:		Employer:	
Referring provider:	Address:		Phone no.: ( )

INSURANCE INFORMATION

(Please provide a copy of your insurance card.)

Primary Insurance:	ID #:	Group #:	
Subscriber's name:	Birthdate: / /	Sex: ❑ Male ❑ Female	Phone no.: ( )
Patient's relationship to subscriber:	❑ Self ❑ Spouse ❑ Child ❑ Other		
Customer service phone no.: ( )	Insurance billing address:		Employer:
Name of secondary insurance (if applicable):	ID #:	Group #:	
Subscriber's name:	Birthdate: Sex: ❑ M ❑ F	Insurance billing address:	Customer service phone no.: ( )
Patient's relationship to subscriber:	❑ Self ❑ Spouse ❑ Child ❑ Other		

IF ACCIDENT RELATED:

Date of accident:	How it happened: ❑ Work ❑ Auto ❑ Other ________________
Insurance company:	Claim #:
Address:	
Claims adjuster:	Phone no:
Attorney:	Phone no:

IN CASE OF EMERGENCY

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.

Patient/Guardian signature ______________________ *Date* ______________

UNION PHYSICAL THERAPY

Health/Medical History

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):

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

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UNION PHYSICAL THERAPY

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

- ☐ Nausea/Vomiting
- ☐ Fever/Chills/Sweats
- ☐ Unexplained weight change
- ☐ Numbness/Tingling Location
- ☐ Bowel/Bladder changes
- ☐ Skin Rash
- ☐ Dizziness
- ☐ Headaches
- ☐ Muscle Weakness
- ☐ Recent Fall
- ☐ Balance Problems
- ☐ Vision Changes
- ☐ Possibly Pregnant

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)

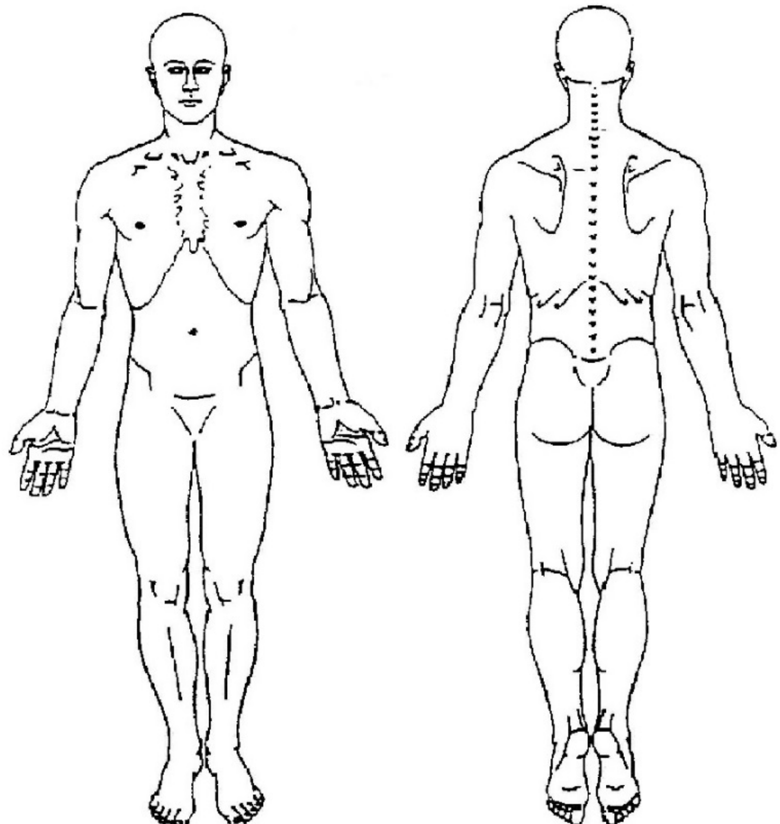
0-25% 26-50% 51-75% 76-100%

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: ____________

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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

O 1 2 3 4 5 6 7 8 9 10

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
(Ex. Working at a computer, bending forward, etc)	
1.	
2.	
3.	

Health and Wellness Activities (optional)

Activity	Score
(Ex. Rock climbing, mountain biking, etc)	
1.	
2.	
3.	

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