Pelvic Health Physical Therapy, LLC

Therapy on Your Terms

Patient Demographics

Name:____ Date of Birth:_________________

Address:______________________________City: _______________ Zip Code:__________

Best Contact Number:__________________________ (Please circle type: Cell, work, home)

Is it okay to send text messages to this number?_________

Email:_________________________________ Occupation:____________________________

Emergency Contact Name and Number:____

Referring Physician:____

Health History

Chief Complaint:____

When/How did it begin:____

____

____

What makes the pain worse? ____

What makes the pain better? ____

Please rate your pain on the 0-10 scale (0 is none, 10 is worst) for the following questions:

In the last two weeks, how high has your pain spiked at its absolute worst?______________

In the last two weeks, how low has your pain been at its absolute best?_________________

What is your level of pain at this moment?______________

Are your symptoms: _______Improving _________Worsening ________ Stable

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Have you ever had treatment for this condition before? If so, what? And did it help?_______

____

____

What are your goals for physical therapy? ____

____

Please list any other ongoing medical conditions you are being treated for?______________

____

____

Please list any medications (including supplements) that you are taking:_________________

____

____

Please list any surgeries you have had: ____

____

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PELVIC HEALTH PHYSICAL THERAPY, LLC

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Billing Policy Agreement

I understand that I am responsible for the full amount of my physical therapy charges prior to my appointments. I understand that it is my responsibility to submit any bills directly to my insurance carrier if I wish to be reimbursed with my out-of-network benefits. I understand that some insurance companies require medical or administrative pre-authorization for treatment, and that it is my responsibility to request this prior to beginning my therapy at Pelvic Health Physical Therapy, LLC. I understand that I am responsible for knowing and meeting the requirements of my insurance plan.

Signature:____ Date:__________________

Printed Name: ____

Cancellation/No Show Agreement

Pelvic Health Physical Therapy, LLC respects their patient's time and will only ever schedule one patient at a time. Once you accept an appointment, you are committing to this time as well. If you should need to cancel, you must notify Pelvic Health Physical Therapy, LLC **at least 24 hours prior to your appointment or you will be charged a $45 no show/late cancellation fee that must be paid prior to any future scheduled appointments.**

I, ___________________________________, understand the 24 hour cancellation policy and agree to comply with it.

Signature: ____ Date: _________________

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HIPAA Notice of Privacy Practices

By signing below, I acknowledge that I have been provided access to the Practice Notice of Privacy Practices, which contains a detailed description of the uses and disclosures of my health information and I have been given an opportunity to read the Notice.

Signature:____ Date:_________________

Printed Name: ____

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