SPECTRUM THERAPY CONSULTANTS

PATIENT INFORMATION FORM

(Please Print)

Patient Name (First, Last, M.I):_____ Date of Birth: _____

SSN: _____ Gender (Circle One): F / M / U Marital Status (Circle One) : S / M / D / W

Current Mailing Address: (Street) _____ (City, State & Zip) _____ APT #: ____

Email Address (confirm appointments/newsletter): _____

Home Phone: _____ Cell Phone: _____

Emergency Contact Name/Relationship: _____ Phone#: _____

Will you be driving yourself to Physical Therapy? (Circle One) Yes / No

Are you currently employed? (Circle One) Yes / No / Student / Retired

If so, Occupation: _____ Employer Phone No. _____

Employer Address: _____

Method of Contact for appointment reminders: (Circle One) Text / Call / Email

Who can we thank for referring you?

Dr. _____ Home Health _____ Social Media _____ Other _____

Do you have other needs for Physical Therapy services besides the reason you are here? Yes / No

If yes, for what conditions/areas? : _____

(Complete only if patient is a minor with guarantors' information)

Full Name: _____ Date of Birth: _____

SSN: _____ Gender (Circle One) : F / M / U Marital Status (Circle One) : S / M / D / W

Mailing Address: _____ APT #: _____

Email Address (confirm appointments/newsletter): _____

Home Phone: _____ Cell Phone: _____

Insured's relationship to patient: _____

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Name: _____ DOB: _____ Date: _____

Weight (lbs.): _____ Height (ft/in): _____

Have you RECENTLY noted any of the following (check all that apply)?

☐ Changes in bowel/bladder	☐ Weight loss/gain	☐ Fever/chills/sweats
☐ Nausea/vomiting	☐ Shortness of breath	☐ Unexplained pain at night
☐ Difficulty maintaining balance while walking	☐ Headaches without cause	☐ Difficulty swallowing
	☐ Changes in appetite	

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

☐ Cancer (type) _____	☐ Stroke	☐ Kidney/liver problems
☐ Heart Disease	☐ Depression	☐ Stomach Ulcers
☐ High Blood Pressure	☐ Anemia	☐ Epilepsy
☐ Asthma	☐ Lung Problems	☐ High Cholesterol
☐ Pacemaker Inserted	☐ Thyroid Problems	☐ Other
☐ Osteoporosis	☐ Osteoarthritis	
☐ Rheumatoid Arthritis	☐ Diabetes	

Please List current Medication List (or provide list):

_____

_____

Please list any surgeries (including year performed or provide list):

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Pain at its LOWEST:

0 1 2 3 4 5 6 7 8 9 10

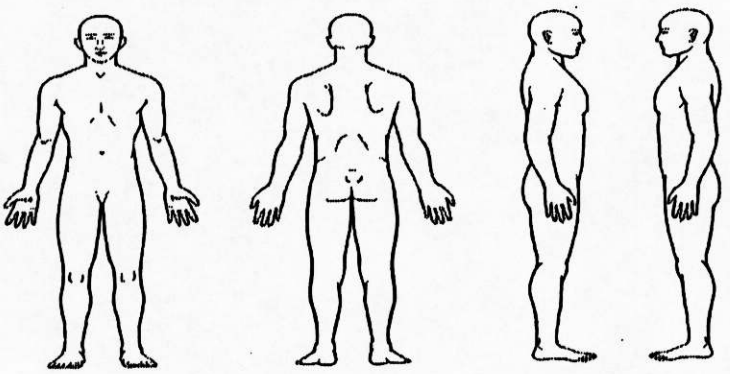
Pain CURRENTLY:

0 1 2 3 4 5 6 7 8 9 10

Pain at its HIGHEST:

0 1 2 3 4 5 6 7 8 9 10

Body Chart (Please mark the location of your pain):



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Home Health: Are you currently receiving home health care for any reason? Yes / No

This would include anyone going to your home to bathe you or provide dressing changes, vitals, blood levels and skilled nursing.

If Yes. Provide the name of the agency, dates of treatment and sign a **Medical Release Form:**

Name of Agency: _____ Dates of Treatment: _____

Reminder Calls/Text/Emails

I permit for my phone number & email to be used for appointment reminders, I also permit that my email to be used for Spectrum Therapy Consultants Newsletter, that provides valuable musculoskeletal tips for injuries and conditions, I am aware that I may unsubscribe at any time.

Consent for Care and Treatment

I agree and give my consent for Spectrum Therapy Consultants to furnish medical care and treatment to the patients that is considered medically necessary in treating his/her physical condition in office or via TELEHEALTH.

Release of Information

I hereby authorize the release of all information necessary, including Medical records.

Benefit Assignment/ Financial Policy Statement

I hereby authorize and request that payment of benefits by my primary insurance company, and my secondary insurance (if any) be made directly to Spectrum Therapy Consultants for services furnished to me or my dependent. I understand that my insurance company may only cover a portion of the total bill. I further understand that I may be responsible for all charges not covered by this assignment. I have made payments arrangements for any co-pay, co-insurance and/or deductible I may be responsible for. As a courtesy, Spectrum Therapy Consultants will verify benefits and provide patients with a per visit estimate via Medicare allowable fee schedule as most insurances following Medicare fee schedule. Should the insurance make a direct payment to the patient; I understand that I am responsible for paying Spectrum Therapy Consultants. I also understand that there will be a $30 fee for any returned checks payable to Spectrum Therapy Consultants. Patients are encouraged to contact their insurance carrier to verify their benefit information.

I have read and fully understood the above information and my insurance benefits.

_____ _____

Patient/Guardian/Responsible Party Date

Revised: 04/27/2020

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Cancellation Policy

In the event you need to cancel an appointment, we request at least a **24-business hour notice.** Your appointment time is very important to us. The notice of cancellation is imperative, as we may not be able to schedule another patient who may need that time slot. **If we do not get at least 24-buisness hour notice of your cancellation in advance, you will be assessed a cancellation fee of twenty-five ($25.00) that is not covered by your insurance company.**

Repeated late cancellation or no show are disruptive in delivery of care and may indicate lack of commitment to your health and wellness. As a result, **3 late cancellations or no shows,** will result in discontinuing physical therapy. In the event you are discharged from our care, your referring provider or case manager will be notified of the reason for discharge from physical therapy.

Arriving on time for your appointment is also important to receiving the best care possible. Chronic late arrivals disrupt the success of your individual care plan. Arriving more than **15 minutes late for 3 or more visits** may result in discontinuing physical therapy. In the event, your referring provider or case manager will be notified of the reason for discharge from physical therapy.

I understand Spectrum Therapy Consultants appointment cancellation policy and understand my responsibility to plan appointments accordingly and notify Spectrum Therapy Consultants appropriately if I have difficulty fulfilling my scheduled appointments.

_____ _____

Patient/Guardian/Responsible Party Date

Notice of Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practice may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

**Please advise if you would like a full copy of the notice of privacy practice.

_____ _____

Name of Patient (Print) Date

_____ _____

Signature of Patient/Guardian/Responsible Party Relationship to Patient

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