Date/Time of IE: _____ Date: _____

Patient Information

Last Name: _____ First Name: _____

Date of Birth: _____ Marital Status: ☐ Married ☐ Single ☐ Divorced

Home Address: _____ Apt#_____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Would you like to receive appointment reminders? ☐ Text ☐ Email ☐ None

Employer: _____ Occupation: _____

Email address: _____

Would you like to receive email updates from Poke & Prod Physical Therapy? ☐ Yes, please ☐ No, thank you

Spouse Name: _____ Spouse Employer: _____

Referring Physician: _____ Dx/Reason for Visit: _____

How were you referred to Poke & Prod PT?: _____ Date of RX: _____

Insurance Information

Name of Primary Insurance: _____

Policy Holder Name: _____ Relationship to patient: _____

Subscriber Date of Birth: _____ Group#: _____ Policy/ID#: _____

Insurance Phone No: _____

Name of Secondary Insurance: _____

Policy Holder Name: _____ Relationship to patient: _____

Subscriber Date of Birth: _____ Group#: _____ Policy/ID#: _____

Insurance Phone No: _____

You expressly consent to be contacted, by Poke & Prod Physical Therapy or anyone calling on its behalf, for any and all purposes, at any telephone number, or physical or electronic address you provide or which you may be reached, including any wireless telephone number. You agree that Poke & Prod Physical Therapy may contact you in anyway, including calls or prerecorded or artificial voice or text messages delivered by an automated telephone dialing system, or email address delivered by an automatic emailing system.

You expressly acknowledge that this consent cannot be revoked without prior agreement and acceptance by us. You agree to promptly notify us at any time your contact information changes.

_____ _____

Patient/Guardian Signature Date

Insurance Information

Patient Name: _____ Age: _____ Sex: F_____ M _____

What is your main complaint and in what area is it located? _____

_____

Occupation: _____ Are you presently working? ☐ Yes ☐ No

If no: Last Day Worked: _____

Have you ever had these symptoms before? ☐ Yes ☐ No If yes, When? _____

Have you had physical therapy, occupational therapy or chiropractic care for this injury before? ☐ Yes ☐ No

Which one and when? _____

Check all of those which apply to your current condition:

☐ Work Related Injury	☐ Sports Injury	☐ Motor Vehicle
☐ Accident	☐ Aggravation of Pre-Existing Injury	☐ Causes Unknown
☐ Injury Recurrence	☐ Lifting Injury	☐ Fall

What have you been doing to decrease your pain? _____

On a scale from 0 (no pain) to 10 (very severe pain), what is your pain level? _____

Are your symptoms getting worse / better / the *same* since your injury? _____

Are you currently taking any medications? (Please list) _____

_____

Are you allergic to any medications? (If yes, please list) _____

_____

Do you have, or have you had any of the following (circle)?

Diabetes	Cancer	Metal Implants	Headaches	Nausea/Vomiting
Chest Pain	Asthma	Dizziness	Kidney Problems	Ear Ringing
Heart Disease	Arthritis	Fractures	Bladder Problems	Hypoglycemia
Pacemaker	Aids/HIV	Skin Allergies	High Blood Pressure	Seizures
Allergies to Cold	Allergies to Heat	Respiratory Problems		

Are You Pregnant? ☐ Yes ☐ No

If you answered yes to any of the above, please explain and give an approximate date of occurrence:

_____

Please circle tests you have had performed:

None X Rays MRI CT Scan Bone Scan Other: _____

Please circle any of the following activities which you have difficulty with due to your injury:

Housekeeping	Lifting	Driving	Shopping	Reaching
Dressing	Cooking	Climbing Stairs	Child Care	Bending
Yard Work	Sit to Stand			

List all of your surgeries: _____

Is there any other information about your present health that we should know about? _____

_____

_____ _____ _____

Patient Signature Date PT/*OT* Initials

Consent for Care and Treatment

I, the undersigned, do hereby agree and give my consent for Poke & Prod Physical Therapy to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition. I understand that I am financially responsible for payment of all services that are not paid by my insurance carrier. The undersigned also agree(s) to pay all collection costs incurred, in an amount not to exceed fifty percent (50%) of the unpaid balance, should any unpaid balance be referred to a collection agency. In addition, should any unpaid balance due be referred to an attorney for litigation, all reasonable attorney fees and court costs shall be paid for by the undersigned as allowed by the Court.

Release of Information

I hereby authorize Poke & Prod Physical Therapy to obtain any and all medical records concerning my care from any physician, hospital or health care professional that has provided medical care to me in the past. I also authorize Poke & Prod Physical Therapy practice to release any and all medical records concerning my care to any physician, hospital or other health care professional providing care to myself / and or child at any time. By signing this form, I consent to the Practice's use and disclosure of my health information for treatment, payment and health care operations. I understand that I have the right to revoke this consent at any time in writing, but if I do, my revocation will not have an effect on any actions the Practice has already taken in reliance of this consent.

Cancellation and No-Show Policy

If you are unable to keep a scheduled appointment, please notify us at least 24 hours in advance. We will make every attempt to reschedule your appointment. If you miss your appointment without calling in advance, you will be charged a $50.00 no-show fee. This payment takes effect on your second missed appointment without previous notice. All cancellations and no-shows are documented in your medical record. Case managers and referring physicians for worker's compensation patients are notified after each missed appointment.

HIPAA Privacy Acknowledgement

I acknowledge that I have been given a copy of the Practice's "'HIPAA Privacy Policy Notice", which describes the Practice's obligations to ensure the privacy of my health information. The HIPAA Privacy Notice also describes how the Practice may use and disclose my health information for treatment, payment and health care operations. I know that I have the right to review the Practice's HIPAA Privacy Notice and to ask questions about it. I understand that the Practice is required to maintain the privacy of my health information in accordance with the terms of its HIPAA Privacy Notice. I further acknowledge that the Practice can change its HIPAA Privacy Notice in the future and that I can receive a copy of the Practice's current Privacy Notice at any time.

In compliance with HIPAA regulations, I consent to the following individuals receiving verbal information regarding the billing of my account. (Optional).

_____ Name/Relationship

_____ Name/Relationship

_____ Name/Relationship

_____ Patient/Guardian Name (Print)

_____ Patient/Guardian Signature

_____ Date