Physical Therapy Now, L.L.C.
1 Alpha Drive East
Pittsburgh, PA 15238
Phone: (412) 860-7994 Fax: (412) 828-0116

New Patient Information Sheet

Name: ______________________________________ Date of Birth: _________________ M_____ F_____

SS #: ___________________________ Marital Status: S_______ M _______ D _______ W _______

Address: _________________________________ City: ______________________ State: ______ Zip: __________

Home Phone: __________________________ Cell Phone: ___________________ Work: ___________________

Email Address: _______________________________________ Primary Dr: _____________________________

Primary Dr. Phone:_____________________________ Primary Dr. Fax:_____________________________

Address:_________________________________ City:______________________ State:______ Zip:___________

Employer: ____________________________________ Address: ____

City: _____________________________________ State:______ Zip:______________

Emergency Contact: ___________________________ Relationship: ____________ Phone: __________________

Account Responsibility: Self______ Spouse_______ Other:_______ Name: _____________________________

Primary Insurance Name: ______________________________________ Phone #: ______________________

Subscriber Name: ________________________ Relationship: __________ Date of Birth: _________________

Policy ID #: ___________________________________ Group #: ____________________

Secondary Insurance Name: ______________________________________ Phone #: ______________________

Subscriber Name: ________________________ Relationship: __________ Date of Birth: _________________

Policy ID #: ___________________________________ Group #: ____________________

How will you pay for your copay, coinsurance and/or deductible? Cash____ Check____ Credit Card____

*****PLEASE PRESENT YOUR INSURANCE CARDS TO THE RECEPTIONIST FOR COPYING*****

Patient Signature: ______________________________________ Date: ________________________

PHYSICAL THERAPY NOW LLC.

PATIENT MEDICAL HEALTH QUESTIONNAIRE

Name: ____ Age: _____ Date of Evaluation: ________

Weight ____ lbs. Height: _____ Marital status: ______ Sex: M F

Main Problem (How and when it started): ____

____

Other recent treatment: ____

Tests (x-ray, MRI, etc.): ____

Surgeries (What and when): ____

Medications currently using: ____

____

Allergies to tape, soap, latex, medication, other: ____

Please explain: ____

MEDICAL SCREENING
(Circle Yes or No)

Have you been told that you may have or have been treated for:

Condition			Condition		
Arthritis/joint problems	Yes	No	Hepatitis	Yes	No
Angina/chest pain	Yes	No	Hernia	Yes	No
Asthma	Yes	No	Joint replacement	Yes	No
Balance problems	Yes	No	Kidney disease	Yes	No
Blood disease	Yes	No	Neck or back problems	Yes	No
Blood pressure	Yes	No	Nerve damage/disorder	Yes	No
Blood thinner currently	Yes	No	Numbness/tingling	Yes	No
Bowel or bladder problems	Yes	No	Osteoporosis	Yes	No
Bronchitis	Yes	No	Pacemaker	Yes	No
Cancer	Yes	No	Pregnant currently	Yes	No
Circulation/phlebitis	Yes	No	Rheumatic fever	Yes	No
Depression	Yes	No	Seizures	Yes	No
Diabetes	Yes	No	Shortness of breath	Yes	No
Dizziness	Yes	No	Spinal surgery	Yes	No
GERD	Yes	No	Stroke	Yes	No
Headaches	Yes	No	Tuberculosis	Yes	No
Hearing problems	Yes	No	Ulcers	Yes	No
Heart disease	Yes	No	Unexplained weight loss	Yes	No
Heart attack	Yes	No	Vomiting	Yes	No

I currently have difficulty…….check all that apply:

( ) driving ( ) getting up from a chair
( ) walking ( ) bending at the waist
( ) standing ( ) lifting

How are you able to sleep at night? (check one)

( ) fine ( ) moderate difficulty
( ) only with medication

Are your symptoms: (check one)

( ) getting worse ( ) the same
( ) improving

Do you or have you in the past smoked tobacco? (Please circle) Yes / No
If yes, # packs ________ number of years __________
Last tobacco use ______________________________

The above statements are true to the best of my knowledge.

____ _____________________________________

Signature Date

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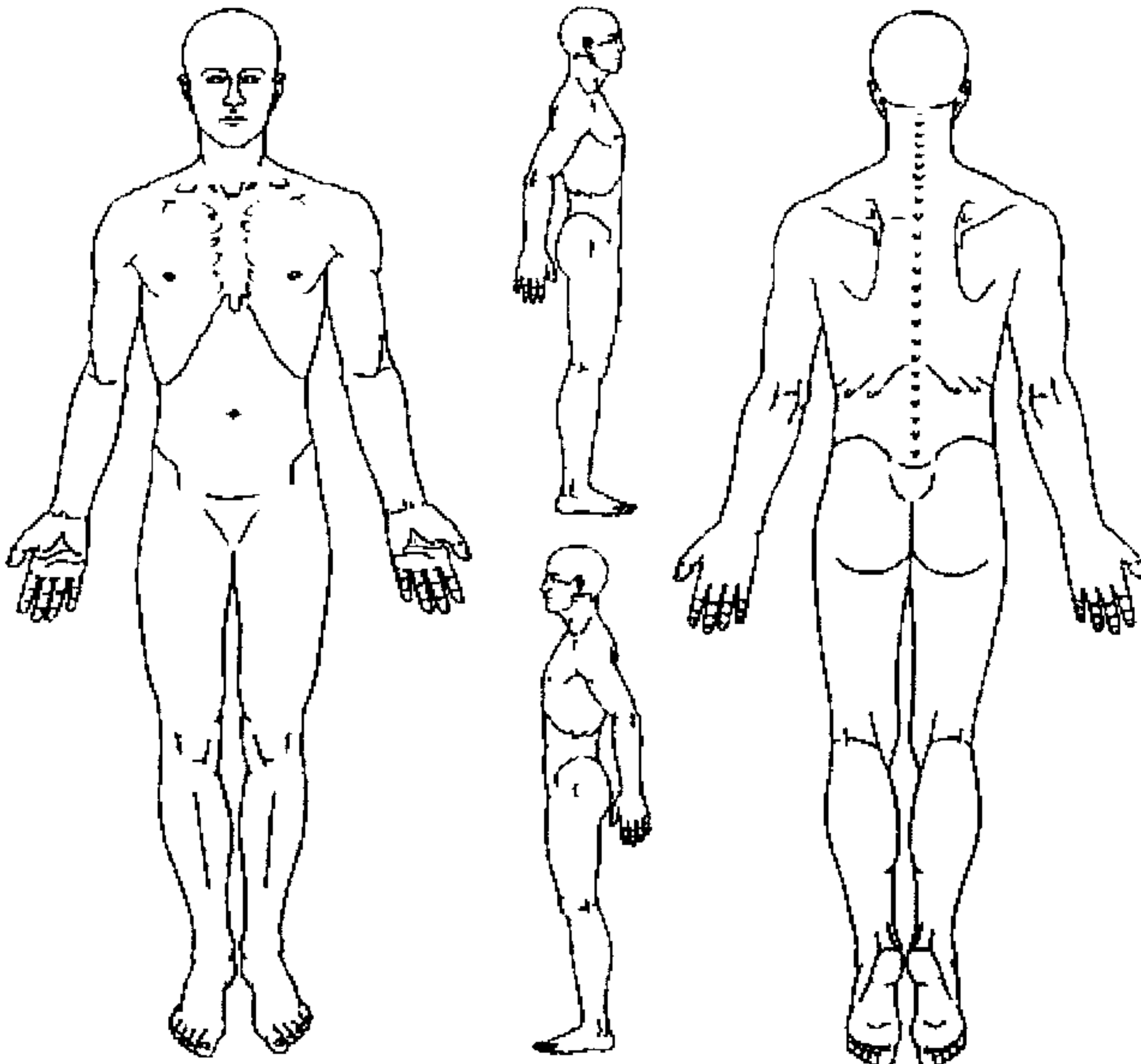
Michael A. Ricchiuto, MPT - Licensed Physical Therapist

PATIENT PAIN DIAGRAM

NAME ____ DATE _______________

How long have you had pain? _______years ________months _______weeks _______days

On the diagram below, please indicate where you are experiencing pain or other symptoms, right now.



A = ACHE	B= BURNING	N = NUMBNESS
P = PINS & NEEDLES	S = STABBING	O = OTHER

Place the above alpha characters on the diagram, indicating the locations and symptoms of your pain.

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CONSENT TO PHYSICAL/OCCUPATIONAL/SPEEECH THERAPY EVALUATION/TREATMENT

I consent to physical/occupational and/or speech therapy evaluation and treatment by a licensed physical/occupational/speech therapist employed or contracted with Physical Therapy Now, LLC.

I can expect the therapist to explain to me the purpose of the evaluation and proposed treatment plan. The therapist will explain to me the expected outcome in addition to the risks that I may encounter from receiving skilled therapy care. I understand that my condition may worsen if I decline to receive treatment.

I also understand that physical/occupational and/or speech therapy treatment does not always provide beneficial results and though unlikely, may even increase my complaints. I am aware that I am encouraged to ask questions and can expect satisfactory responses from the treating therapist.

I have read this consent form and completely understand its contents. The physical/occupational /speech therapist is present to witness my signature of consent.

Patient or responsible person:

____________________________ ____________________________
Print Name Signature

____________________________ ____________________________
Relationship of responsible person if not signed by patient Date

I certify that I have fully explained the purpose, benefits, complications and available treatment options to the proposed evaluation and treatment. I have completely answered all patient questions to the best of my knowledge/ability. In my opinion the patient/responsible person completely understands all of my explanations/answers to their proposed questions.

____________________________ ____________________
Michael A. Ricchiuto, MPT Date
LICENSE # PT015313

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AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Physical Therapy Now LLC the use or disclosure of □ my □ my child's □ or (give relationship ________________________) individually identifiable health information for the purposes of Treatment, Payment and Health Care Operations.* I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations, and that it may be re-disclosed by the recipient.

> * ***Treatment*** *includes activities performed by a health care provider, nurse, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any physician who covers my/our practice by telephone as the on-call physician.*
> * ***Payment*** *includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization.*
> * ***Health Care Operations*** *includes the necessary administrative and business functions of our office.*
> * ***Video Recording*** *may occur during the treatment session. This information may be used to assess further treatment options.*

I further authorize PHYSICAL THERAPY NOW LLC to use and disclose the following specific health and medical information for the following individuals and for the below listed purpose(s):

Authorized Individuals to receive specific health and medical information:

Specific medical information consisting of:

For the specific purpose of:

Video recording of treatment:

You have the right to revoke this Authorization at any time, providing that you do so in writing and except to the extent that we already used or disclosed the information in reliance on this Authorization. Unless revoked earlier or otherwise indicated, this authorization will expire on December 31, 2011

Patient Information (Please Print):

________________________ ________________________ ________________
Last Name *First Name* *Middle Initial*

________________ ________________ ________ ________ ________________
Address *City* *State* *Zip Code* *Phone Number*

________________________________ ________________
Signature of Patient or Representative *Date*

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I acknowledge that I have received PHYSICAL THERAPY NOW'S Notice of Privacy Practices for protected health information.

________________________ ________________________ ________________
Patient Name (please print) *Signature of Patient or Representative* *Date*

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Patient's name ____

ASSIGNMENT OF INSURANCE BENEFITS

I authorize and direct my insurance carrier to pay to Physical Therapy Now, LLC. as it's interests may appear, all benefits under my insurance policy now due or that may become due as a result of therapy services provided to me.

I am responsible for all financial obligations of therapy services provided, and for reimbursement and payment of claims from my insurance company. If for any reason the account should become delinquent, I agree to pay for all interest charges, collection costs and any reasonable legal fees. I accept responsibility for payment of any deductible and co-insurance from my insurance policy.

I authorize and direct Physical Therapy Now, LLC. to furnish any and all information and record of treatment and services rendered to me related to this claim.

If I have decided to receive physical therapy services on a private pay basis and will not utilize my insurance benefits for any reason, I agree to pay the out-of-pocket rate of $_________ per session. All private pay transactions are nonrefundable.

_______________________________________   ______________
Signature of Patient/Guardian   Date

_______________________________________   ______________
Signature of Witness   Date

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It is the policy of Physical Therapy Now, LLC to accept payment for services rendered from your participating insurance. However, most insurance companies require the patient to pay a co-pay, and/or a deductible. **Per insurance contractual obligations, we are required to collect all payments at the time of treatment *unless payment arrangements are made prior to your treatments.*** This would be the time to discuss payment arrangements with our staff concerning this policy.

Deductibles and out-of-pocket payments will be billed to your home address. Payment plans can be arranged so that lump sum payments can be avoided. You are encouraged, again, to discuss payment arrangements at the time of the evaluation. You are aware that physical, occupational, and speech therapy copays usually apply per each visit as determined by your specific insurance plan and treatment visits are usually 2-3 times per week per discipline as determined by your treating therapist. Please discuss the frequency of visits with your therapist before the beginning of treatment as you will be responsible for all copays, deductibles and out of pocket money as determined by your insurance company.

At Physical Therapy Now LLC, we are primarily concerned with your health! Therefore, **PLEASE DO NOT** be discouraged from attending your therapy or scheduling future appointments based on payment of co-pays and deductibles determined by your health insurance carrier. Please review your insurance policy to determine possible co-pays and deductibles that your insurance company has pre-determined, and that you may be obligated to pay. We will be more than happy to arrange a payment schedule that will fit your budget.

My signature below acknowledges that I do understand the above policy and plan of Physical Therapy Now LLC. While understanding this policy, I do agree to pay all co-pays and deductibles determined by my insurance company that are owed to Physical Therapy Now LLC., for evaluations and treatments by this company.

______________________________	______________________________
Patient name (Print)	**Responsible Party (Print)**
______________________________	______________________________
Patient/ Responsible Party Signature	**Date**
______________________________	______________________________
Signature of witness	**Date**

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APPOINTMENT CANCELATION POLICY

If you are unable to keep your scheduled appointment time, please notify the office by calling within 24 hours of your appointment time. There may be unforeseen emergencies that will prohibit you from calling and that will be taken into consideration by our office if you make the effort to call and explain those reasons at a later time.

It is the policy of Physical Therapy Now, LLC to charge a **$20.00** fee for each patient appointment that was **not canceled** within 24 hours of the scheduled appointment time. The charge will be reflected on your monthly statement as a "missed appointment – not notified".

Physical Therapy Now **CANNOT** keep your appointment time pending until you are able to arrive. We allow only a **15 minute** window for regular scheduled appointments. If you arrive **more than 15 minutes** after your regular scheduled appointment time, that appointment will have to be rescheduled to another date and time.

There will be no fees for therapist canceled appointments. We will make every effort to notify you in advance, if a therapist needs to cancel appointments for the day. We will try to find coverage for all appointments so that your appointment does not need to be canceled or rescheduled.

******PLEASE NOTE**** WE DO NOT ACCEPT WALKIN APPOINTMENTS**

Patient's name ____
Please print

______________________________ ______________
Signature of Patient/Guardian Date

______________________________ ______________
Signature of Witness Date