



Date: _____

Patient Name: _____
Last

Address: _____
First Middle Initial

City: _____ St: _____ Zip: _____

E-Mail: _____

Phone: (_____) _____

Cell Phone: (_____) _____

Sex Male Female

DOB: _____

Married Single Minor Divorced

Separated

Occupation: _____

Employer/School: _____

Employer/School Phone: (_____) _____

Spouse's Name: _____

Spouse's DOB: _____

Spouse's Employer: _____

Whom may we thank for referring you?

IN CASE OF EMERGENCY, CONTACT

Name: _____

Relationship: _____

1st contact #: (_____) _____

Is this condition due to an accident: Yes No

Date of accident: _____

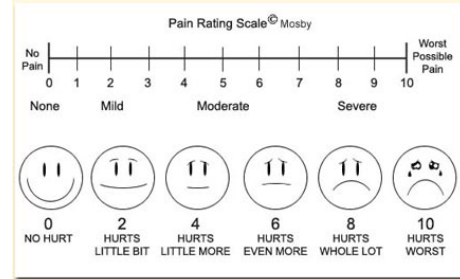
Type of accident: Auto Work

Are you being represented by an attorney for this accident?

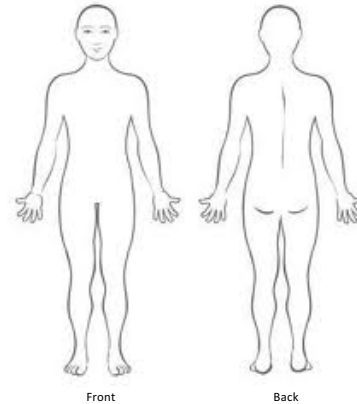
Attorney name (if applicable): _____

Phone (_____) _____

Rate the severity of your pain:



Mark an X on the picture where you have pain, numbness, weakness or tingling.



Primary Doctor: _____

Pharmacy: _____

Medications (prescriptions and OTC) _____

Allergies: _____

Health History

- | | | |
|--|--|--|
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Headaches | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Hernia | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Urinary Tract Infection | <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Vascular Disease | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> COPD |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Circulatory Problems |
| <input type="checkbox"/> Low Blood Sugar | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Numbness/Tingling |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Guillain-Barre Syndrome |
| <input type="checkbox"/> Fever/Chills | <input type="checkbox"/> Pacemaker/Defibrillator | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> GERD | |

Other Medical Conditions _____

Pregnant: Yes No Due date: _____

I would rate my health as: Excellent Good Fair Poor

Have you had any falls in the last six months? If yes, approximately how many? _____

Orthopedic History: _____

Surgeries _____

PATIENT NAME: _____

EXETER PHYSICAL THERAPY FINANCIAL POLICY

We would like to THANK YOU for choosing Exeter Physical Therapy. Exeter Physical Therapy accepts third party payments and will submit your bills for treatment to the address provided as a courtesy to you. In order for us to bill your insurance company on a regular basis, we request that you sign this release of information and assignment of benefits (if applicable). Typically, insurances pay a predetermined amount of our treatment charges; however it is your responsibility to call your insurance company to check on the coverage provided by your individual policy. As a courtesy to you, we will perform an insurance verification with your insurance company; however we will not take responsibility for any misinformation that we are given during this process. Therefore, it is within your best interest to verify your outpatient benefits with your individual insurance plan and to confirm them with our office prior to initiating treatment.

Please initial after each Acknowledgement

CONSENT FOR CARE AND TREATMENT: I hereby give written consent for the provision of treatment. I authorize Exeter Physical Therapy to furnish treatment which is considered necessary and proper in diagnosing or treating my physical condition.

FINANCIAL RESPONSIBILITY: I understand that in some instances the applicable insurance may not cover all treatment charges incurred. I agree to be financially responsible to Exeter Physical Therapy for any medically necessary therapeutic services that are deemed uncovered by my insurance policy.

ASSIGNMENT OF BENEFITS: I hereby authorize payment directly to Exeter Physical Therapy, any benefits payable to me and/or my qualified dependents under the insurance coverage or Major Medical provisions of insurance coverage identified on bills submitted by Exeter Physical Therapy for treatment.

CO-PAYMENTS: I understand that if my insurance plan requires a co-payment for treatment, my co-payment will be collected at the time of my visit. A surcharge may be applied in order to collect late co-payments. This surcharge will cover expenses incurred by Exeter Physical Therapy to generate additional bills and/or utilize collection services.

LITIGATION ACCOUNTS: I understand that Exeter Physical Therapy will directly bill my appropriate insurance; however I am responsible for the payment of my treatment, not the entity being sued. Liability action against someone else will not enable me to refuse payment to Exeter Physical Therapy.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES AND AUTHORIZATION: I hereby acknowledge that I have received a copy of Exeter Physical Therapy's Notice of Privacy Practices. I also understand that additional copies of the Notice are available for my review upon request. By way of my signature below, I provide Exeter Physical Therapy with my authorization and consent to use and disclose my protected health information for the purposes of treatment, payment and health care operations as described in the Notice of Privacy Practices.

CERTIFICATION OF IDENTITY: I certify that I am in fact the individual claim to be. I understand that the knowing and willful use of another individual's personal identifying information under false pretenses is a criminal offense.

Photo Release: I grant Exeter Physical Therapy, its representatives and employees the right to take photographs of me and my property in connection treatment, office function and social media purposes. Verbal permission will also be attained before any posting to social media accounts.

I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND ALL COMPONENTS OF EXETER PHYSICAL THERAPY FINANCIAL, PRIVACY AND CANCELATION POLICIES AS STATED ABOVE.

Signature of patient or guardian _____ **Date** _____

