Date:_____

Patient Name:_____
Last
_____
First Middle Initial
Address:_____
City:_____St:_____Zip:_____
SS#:_____
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 #:(_____)_____

Insurance Information
Primary Insurance Company:
_____

Patient relationship to insured:_____

DOB of insured:_____

Is patient covered by additional insurance?
☐ Yes ☐ No
_____
Secondary Insurance:_____
ID: #_____Group# _____

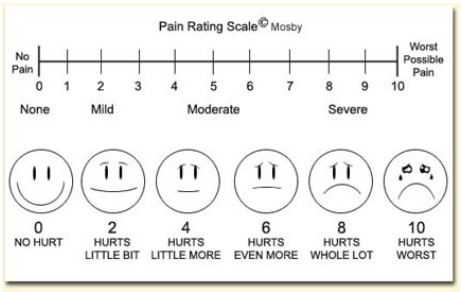
Is this condition due to an accident: ☐ Yes ☐ No

Date of accident:_____
Type of accident: ☐ Auto ☐ Work

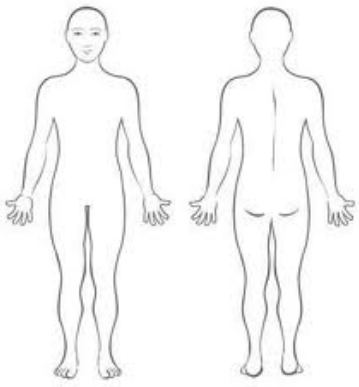
Are you being represented by an attorney for this accident?
Attorney name (if applicable):
_____
Phone (_____)_____

EXETER PHYSICAL THERAPY

Rate the severity of your pain:



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



Front Back

Primary Doctor:_____

Pharmacy:_____

Medications (prescriptions and OTC)_____
_____
_____
_____
_____
_____

Allergies:_____
_____

Health History

__ Abdominal Pain
__ AIDS/HIV
__ Anxiety/Depression
__ Urinary Tract Infection
__ Vascular Disease
__ Cancer
__ Chemical Dependency
__ Low Blood Pressure
__ Low Blood Sugar
__ Scoliosis
__ Nausea/Vomiting
__ Fainting
__ Fever/Chills
__ Pneumonia
__ Headaches
__Tuberculos
__ Hernia
__ Asthma
__ Bleeding Disorder
__ Kidney Disease
__ Liver Disease
__ Prosthesis
__ Lyme Disease
__ Dizziness
__ Epilepsy/Seizures
__ Osteoporosis
__ Pacemaker/Defibrillator
__ GERD
__Stroke
__ Hepatitis
__ Ulcers
__ High Blood Pressure
__ High Cholesterol
__Gout
__ COPD
__ Circulatory Problems
__ Diabetes
__ Migraines
__ Numbness/Tingling
__Guillain-Barre Syndrome
__ Fibromyalgia

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. _____

CANCELATION POLICY: We request that you give 24 hours' notice in the event that you cannot make it to your scheduled appointment. If a patient misses an appointment without contacting our office, it is considered a missed or "No Show" appointment. Additionally, if a patient is more than 15 minutes late for an appointment, it will be considered a "no show" appointment, and that appointment will be rescheduled. If you miss more than **3** appointments, Exeter Physical Therapy reserves the right to discharge you from the practice for failing to follow treatment recommendations. _____

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_____

RECORDS RELEASE AUTHORITY

TO: _____

_____

I, _____ HEREBY REQUEST THAT YOU RELEASE
(Patients' name or guardian)
_____ RECORDS TO:

Exeter Physical Therapy
3933 Perkiomen Avenue Suite 101 Lower Level
Reading, PA 19606
610-401-0365 (PHONE) 610-401-0865 (FAX)

A report of my diagnosis, treatment, prognosis, and recommendations, as well as other data pertinent to your treatment of me from _____ to _____**PRESENT**_____ .

__All records __X-rays __MRI Films __Bloodwork __Other_____

I hereby authorize disclosure of the health information for the above named patient. This authorizations **valid for 1 year** From the date of signature. I understand that I may cancel this request with written notification but that it will not effect Any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected By federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition Its treatment of me on whether or not I sign the authorization.

I DO UNDERSTAND THAT THE RELEASING OFFICE/FACILTY MAY CHARGE A FEE FOR THESE RECORDS. THIS FEE IS NOT IN ASSCIATION WITH EXETER PHYSICAL THERAPY.

_____ _____
Patient's OR Guardian's Signature Patient's Name **PLEASE PRINT**

_____
Address

_____
City, State, Zip Code

Patients DOB: _____ _____

Patients SSN: _____ _____

Please: **Fax Report** _____X_____

Mail Films/CD _____