COPPOLA PHYSICAL THERAPY

First Name:	M.I:	Last:
Preferred Name:		
Address:		City/State:
Zip Code:	Date of Birth:	SSN:
Home Phone ☐: ( )	Mobile ☐: ( )	Work ☐: ( )
****Please check which phone number we can leave a voice message regarding treatment dates and times****		
E-mail address:		

Assigned sex at birth: What sex were you assigned at birth, on your original birth certificate? ☐ Male ☐ Female

☐ Identify as something different than above

Employer:		Occupation
Emergency Contact:	Relationship:	Phone: ( )
Health Insurance Name(s): Primary:		Secondary:
Subscriber Name:	DOB:	Relationship:
Primary Care Physician:	Practice:	City/State:
Referred by:	Practice:	City/State:
Reason for Today's Visit:		Date of Injury/Surgery:
Have you had previous P.T. for this injury? **Y / N**	Dates of service:	to
Where did you go for treatment?		How many visits?

How did you hear about us? ☐Friend ☐Physician ☐Radio ☐Web ☐Newspaper ☐Drove by

Other:

Is this a Workers' Compensation Claim? Y / N	Claim Number:	
Workers' Compensation Insurance Company:		
Employer:	Employer Contact Person/ Phone Number:	
Is this an Automobile Insurance Claim? Y / N	State Accident Occurred	
Party Responsible for Payment:		
Automobile Insurance Company:		Claim Number:
Attorney involved? Y / N Name:		Phone Number:

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Medical Information

Past History (please circle)

Asthma COPD Pulmonary Disease
High Blood Pressure High Cholesterol
Vascular Disease Arrhythmia Palpitations
Heart Attack Pacemaker Stroke
Other Cardiac Disease _____
Diabetes Type 1 / Type 2 Hypoglycemia
Cancer (please specify)_____
Depression Anxiety Seizures
Osteoporosis Osteopenia
Fractures (please specify)_____
Pregnancies/Births _____ C-Sections _____
Injuries (please specify)
_____
Allergies (please specify)
_____
Surgeries (please specify)
_____
_____
_____
Other_____
_____
_____

Medications

Name Dosage Frequency Route
_____
_____
_____
_____
_____
_____

Family History

Cancer Cardiovascular Disease Diabetes

Currently, are you or do you have:

Pregnant Chest Pain Infection HIV TB
Hepatitis Light Headedness Dizziness
Fatigue Loss of Consciousness Swelling
Fever Night Sweats Weakness
Numbness Tingling Shortness of Breath
Loss of Bowel or Bladder Control Night Pain
Recent Weight Gain or Loss (more than normal)

Do You Use Tobacco Products? Yes No

How much per day? _____ How long? _____

Rate Your Quality of Health

Poor Fair Good Excellent

Please use the diagram below to indicate the symptoms you have experienced today.

Key:

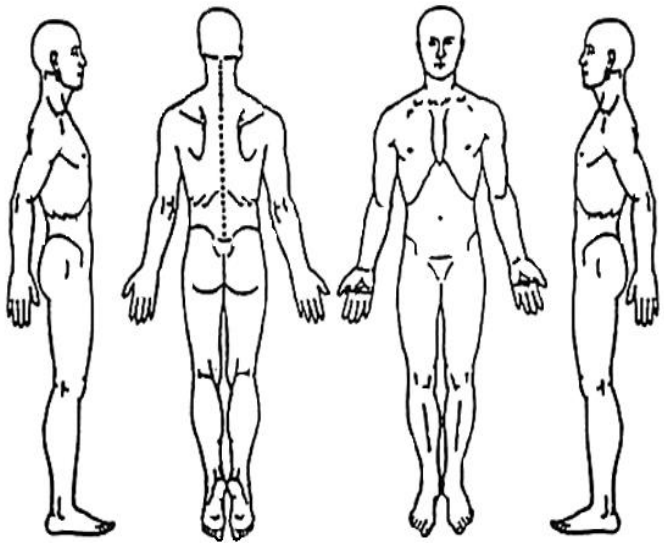
Pins/Needles = O O O

Burning = X X X X X

Stabbing = / / / / /

Numbness = N N N N

Deep Ache = Z Z Z Z



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By signing below I am acknowledging and agreeing to the following:

CONSENT TO EXAMINATION AND TREATMENT: I consent to examination and/or treatment by the physical therapist, assistant, aide, medical technician and/or student of me or the minor patient listed below. This may include, but not be limited to exercise, hands on treatment, or use of medical tools and devices whose purpose will be explained prior to use. I understand that the provider will take into consideration my/minor patient's conditions and use his or her best judgment for my/minor patient's safety to help achieve the goals for the treatment. I understand that I may stop my request for treatment before any procedure or test.

CANCELLATION POLICY: We, at Coppola Physical Therapy, will make every effort to schedule your therapy appointments at a time that is convenient for you. In the event that you cannot attend a particular scheduled appointment, **we ask that you call Coppola Physical Therapy at least 24 hours prior to that appointment to cancel and/or reschedule that appointment. If you do not call to cancel or do not show for a scheduled appointment, you could be charged a $25 fee for a missed appointment.**

If you miss 3 scheduled appointments, we reserve the right to discharge you from therapy. In order to resume therapy after such time you will need to see your physician, obtain another prescription and call us to schedule a re-evaluation.

Also, if you are more than 15 minutes late for your appointment, it will be left to the discretion of your therapist whether or not you will be treated at that time.

I give permission for Coppola Physical Therapy to contact me at home or at my work for any therapy/insurance related issue.

If you have any questions about this policy, please do not hesitate to ask. Thank you advance for your cooperation.

_____	_____	_____
Signature of patient	Name of Patient (please print)	Date
_____	_____	_____
Parent/Guardian Signature	Name of Parent/Guardian	Date

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BILLING AND PAYMENT: If I/minor patient has health insurance coverage, I agree to assign the insurance benefits to Coppola Physical Therapy for payment of the services and supplies provided to me/minor patient.

I understand that Coppola Physical Therapy will:

- Bill my/minor patient's primary and secondary insurance companies for the treatment and supplies provided.
- I agree to pay Coppola Physical Therapy for the balance of any charges not covered by insurance (this includes any deductible, co-payments and coinsurance), for the full amount of the bill for any services that I receive if I do not have insurance, if my workers' compensation claim, if any, is denied, and regardless of how any legal case I may have is resolved.
- I understand that it is my responsibility to obtain any preauthorizations or referrals required by my insurance.
- I understand I will be charged a $25.00 fee for any and all checks returned from the bank for insufficient funds.

MEDICARE or MEDICAID BENEFICIARIES:

- If I am a Medicare or Medicaid beneficiary, I will only be billed for any deductibles, coinsurance, and for services or items provided to me that are not covered by Medicare or Medicaid.
- I certify that the information given by me for payment under Medicare (Title XVIII of the Social Security Act) and/or Medicaid (Title XIX of the Social Security Act) is correct.

NOTICE OF PRIVACY PRACTICES: I acknowledge that I have received Coppola Physical Therapy's Notice of Privacy Practices, and if I wish to obtain another copy, one shall be provided to me.

NO GUARANTEE OF OUTCOME: I understand that no guarantees have been made to me about the outcomes of my treatment.

_____	_____	_____
Signature of patient	Name of Patient (please print)	Date
_____	_____	_____
Parent/Guardian Signature	Name of Parent/Guardian	Date

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Medical Information Release Form

I, for myself, or on behalf of the minor patient listed below, authorize Coppola Physical Therapy and my/minor patient's treating medical providers to discuss and exchange any and all of my/minor patient's medical information as part of Coppola Physical Therapy's treatment of me/minor patient. I understand that this release and exchange of medical information, to the treating or referring providers, may include medical information, of treatment for physical and/or emotional illness, and treatment for alcohol or drug abuse, sexually transmitted diseases, HIV/AIDS, and genetic testing. If I am a Medicare or Medicaid beneficiary, I give my permission to the Social Security Administration to give Coppola Physical Therapy information about my Medicare benefits. Coppola Physical Therapy has my permission to give the Centers for Medicare and Medicaid Services and/or the NH Medicaid Program, or their designees, information about my care in order to receive payment from Medicare/Medicaid.

- I understand that I may revoke this medical information release at any time by notifying Coppola Physical Therapy in writing.
- I understand that signing this release is not a condition of treatment.
- A copy of this form, including facsimile, may be used in place of the original.

Please note, the suggestions below are provided for your convenience to create open lines of communication with all individuals participating in your care. Authorizing communication with the entities is optional; you are not required to authorize any of the categories below.

I authorize you to discuss medical billing or appointment information with the following individuals:

Attorney: _____

Family Members: _____

Other: _____

_____	_____	_____
Signature of patient	Name of Patient (please print)	Date
_____	_____	_____
Parent/Guardian Signature	Name of Parent/Guardian	Date

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