First Name: ______________________________ M.I: _________ Last: ______________________________

Preferred Name: ____

Address: ____ City: ______________________________

State: _______ Zip Code: _________ Date of Birth: ____________ SSN: ____________________________

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

O Identify as something different than above

Home Phone ☐: (   ) ______________ Mobile ☐: (   ) _____________ Work ☐: (   ) _____________

*****Please check which phone number we can leave a voice message regarding treatment dates and times*****

E-mail address: ____ *Would you like to receive our newsletter: Y/N*

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: _________________________

Latest Update: October 25, 2018 Initials:___________

COPPOLA PHYSICAL THERAPY

Medical Information

<table>
<tr>
<td>

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 _________________________

Fractures (please specify)________________

Pregnancies/Births ________ C-Sections ______

Injuries (please specify) __________________

____

Allergies (please specify) _________________

____

Surgeries (please specify)________________

____

____

____

Other__________________________________

____

____

</td>
<td>

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

</td>
</tr>
</table>

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

Key:

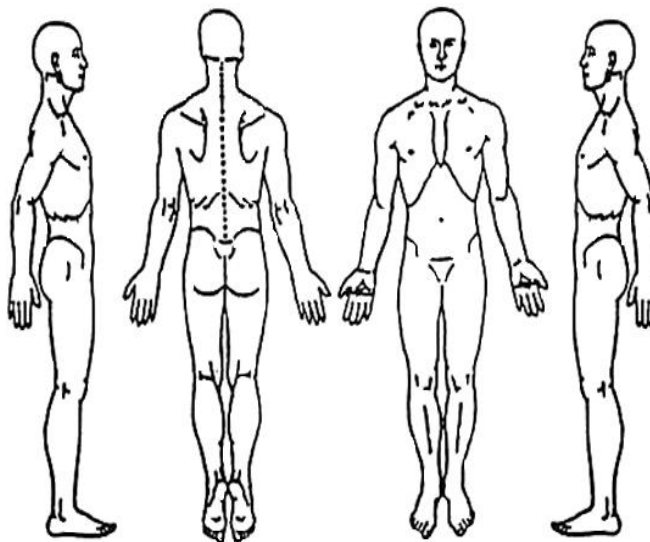
Pins/Needles = O O O

Burning = X X X X X

Stabbing = / / / / /

Numbness = N N N N

Deep Ache = Z Z Z Z



Latest Update: October 25, 2018 Initials:___________

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

Latest Update: October 25, 2018 Initials:__________

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

COPPOLA
PHYSICAL THERAPY

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 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:

Primary Care Physician:____

Other Physician: ____

Attorney: ____

Family Members: ____

Other: ____

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