



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? Male Female

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: _____

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: _____

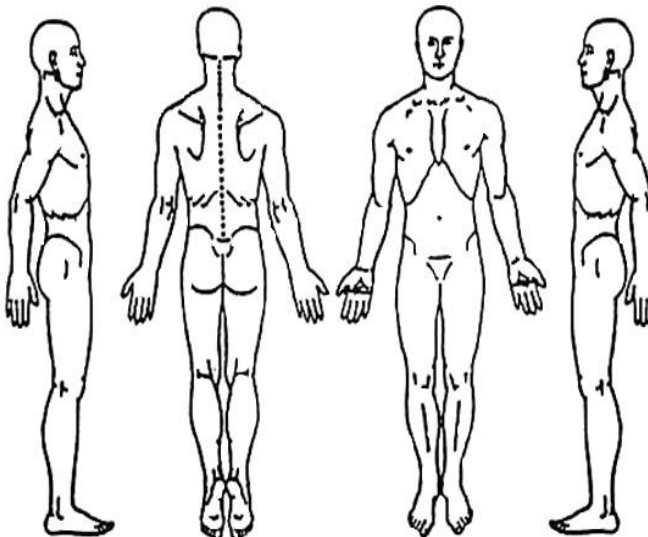
Latest Update: June 27, 2019 Initials: _____ Date: _____

Medical Information

Past History (please circle)	Medications																																																																			
Asthma COPD Pulmonary Disease <hr/> High Blood Pressure High Cholesterol Vascular Disease _____ Arrhythmia Palpitations Heart Attack Pacemaker Stroke Other Cardiac Disease <hr/> Diabetes Type 1 / Type 2 Hypoglycemia Cancer (please specify) _____ Depression Anxiety Seizures Osteoporosis _____ Fractures (please specify) _____ Pregnancies/Births _____ C-Sections _____ Injuries (please specify) _____ <hr/> Allergies (please specify) _____ <hr/> Surgeries (please specify) _____ <hr/> <hr/> Other _____ <hr/> <hr/>	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;">Name</th> <th style="width: 25%;">Dosage</th> <th style="width: 25%;">Frequency</th> <th style="width: 25%;">Route</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="4" style="text-align: center;">Family History</th> </tr> </thead> <tbody> <tr> <td style="width: 25%;">Cancer</td> <td style="width: 25%;">Cardiovascular Disease</td> <td colspan="2" style="width: 50%;">Diabetes</td> </tr> </tbody> </table> <p style="text-align: center;">Currently, are you or do you have:</p> <table style="width: 100%; border-collapse: collapse;"> <tbody> <tr> <td>Pregnant</td> <td>Chest Pain</td> <td>Infection</td> <td>HIV</td> <td>TB</td> </tr> <tr> <td>Hepatitis</td> <td>Light Headedness</td> <td colspan="3">Dizziness</td> </tr> <tr> <td>Fatigue</td> <td>Loss of Consciousness</td> <td colspan="3">Swelling</td> </tr> <tr> <td>Fever</td> <td>Night Sweats</td> <td colspan="3">Weakness</td> </tr> <tr> <td>Numbness</td> <td>Tingling</td> <td colspan="3">Shortness of Breath</td> </tr> <tr> <td colspan="2">Loss of Bowel or Bladder Control</td> <td colspan="3">Night Pain</td> </tr> <tr> <td colspan="5">Recent Weight Gain or Loss (more than normal)</td> </tr> </tbody> </table> <p style="text-align: center;">Do You Use Tobacco Products? Yes No</p> <p>How much per day? _____ How long? _____</p> <p style="text-align: center;">Rate Your Quality of Health</p> <table style="width: 100%; border-collapse: collapse;"> <tbody> <tr> <td style="width: 25%;">Poor</td> <td style="width: 25%;">Fair</td> <td style="width: 25%;">Good</td> <td style="width: 25%;">Excellent</td> </tr> </tbody> </table>	Name	Dosage	Frequency	Route																	Family History				Cancer	Cardiovascular Disease	Diabetes		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)					Poor	Fair	Good	Excellent
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Please use the diagram below to indicate the symptoms you have experienced today.

<p>Key:</p> <p>Pins/Needles = O O O</p> <p>Burning = X X X X X</p> <p>Stabbing = / / / / /</p> <p>Numbness = N N N N</p> <p>Deep Ache = Z Z Z Z</p>





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



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



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: _____

Doctor: _____

Other: _____

Signature of patient

Name of Patient (please print)

Date

Parent/Guardian Signature

Name of Parent/Guardian

Date

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