

# Alton Physical Therapy, P.C.

Getting people better one patient at a time and we'll start today.

Patient's first name \_\_\_\_\_ MI \_\_\_\_\_

Last name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_

Would you like appointment reminders? YES NO

How? Circle one: Email Text Phone

Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_

SSN (req. if WC) \_\_\_\_\_

Employment Status: FT PT Retired Student Unpl

Employer \_\_\_\_\_

Emp. Address (req. if WC) \_\_\_\_\_

Occupation \_\_\_\_\_

Was this an accident? Yes No

Accident Type: Work Auto Other

Date of accident \_\_\_\_\_

State in which accident occurred \_\_\_\_\_

Have you had any physical therapy this year? YES NO

Where? \_\_\_\_\_

How many visits? \_\_\_\_\_

In Case of Emergency, Please Contact:

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Phone \_\_\_\_\_

Today's Date \_\_\_\_\_

Email \_\_\_\_\_

Referring Physician \_\_\_\_\_

Next MD Appt \_\_\_\_\_

Primary Physician \_\_\_\_\_

Reason for today's PT visit \_\_\_\_\_

Date of 1st. Symptom or Injury \_\_\_\_\_

Are you or think you may be pregnant? YES NO

Do you have a pacemaker? YES NO

Rate your pain level from 0-10. 0 = No pain 10 = Worst

Now: \_\_\_\_\_ At worst: \_\_\_\_\_ At Best: \_\_\_\_\_

Medications: \_\_\_\_\_

Surgical History \_\_\_\_\_

Who may we talk to about your care, appointments or billing other than yourself?

## Please Provide Insurance cards to Office Staff and fill in information below if the Insured is not SELF.

Primary Insurance

Insurance Co. \_\_\_\_\_

Insured's Name \_\_\_\_\_

DOB \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Secondary Insurance

Insurance Co. \_\_\_\_\_

Insured's Name \_\_\_\_\_

DOB \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

**Consent to Medical and related Health Care:** I request and consent to the medical care and treatment procedure as determined necessary by my physician(s). I acknowledge the care I receive while in this facility is under the direction of my physician(s).

**Assignment of Benefits:** I hereby irrevocable assign and transfer to THIS FACILITY and all benefits, either contractual, common law, or statutory, to which I am entitled or which are available to me under any medical, health, and accident, or workers' compensation policy, plan or program. I hereby authorize and direct that any such payments be paid directly to THIS FACILITY. Should my insurance policy, or plan description, prohibit direct payment to providers, I direct the payor to issue the provider a check payable to THIS FACILITY and myself. I further authorize and agree that a copy of the authorization shall be deemed valid as the original. This includes the Physical Therapist Lien pursuant to 770 ILCS 75/1.

**Release of Information:** I also authorize Schwegel Physical Therapy, P.C. dba Alton Physical Therapy, P.C. to release any information requested regarding services rendered to me by Schwegel Physical Therapy, P.C. dba Alton Physical Therapy, P.C. , including Medical Records to any third part payor or treating or consulting Physician or medical care provider or employer. This authorization shall remain in effect for 36 months from this date unless sooner revoked by me in writing.

AS A COURTESY TO YOU, WE VERIFIED YOUR OUTPATIENT PHYSICAL THERAPY BENEFITS. WE WILL QUOTE THE BENEFIT SUMMARY AS PROVIDED BY YOUR INSURANCE COMPANY. PLEASE UNDERSTAND THIS IS SIMPLY A VERIFICATION OF BENEFITS, NOT A GUARANTEE OF PAYMENT AS QUOTED BY YOUR INSURANCE COMPANY. WE ENCOURAGE YOU TO CONTACT YOUR INSURANCE COMPANY TO VERIFY PHYSICAL THERAPY BENEFITS.

**PAYMENT FOR MEDICAL AND RELATED CARE, SPLINTS AND DURABLE MEDICAL EQUIPMENT (DME):** I agree to pay the charges incurred for the care I received as ordered by my physican(s) at this facility. I guarantee full payment of all charges unless restricted by Medicare. These charges include, but are not limited to if necessary, to stabilize an emergency medical condition. In the event that I fail to pay these charges, I understand that I will be responsible for reasonable collection costs and attorney fees associated with the cost of resolving my account.

**Teaching Programs:** I understand this facility may, from time to time, enter into agreement with academic programs. Because of these agreements, physical therapy students may participate in my care. I agree to participate in these programs, but have the right to limit my participation at any time.

**Cancellations or Late Arrivals:** Appointments are made to save the patient time and prevent unnecessary waiting and delay. Many people are inconvenienced when an appointment is missed. You, every patient following you and the therapist. If for any reason an appointment cannot be kept or you will be arriving late, notification should be made as far in advance as possible. Your attention to this matter will be greatly appreciated. It is the responsibility of the patient to attend ALL prescribed visits from your ordering physician(s) to ensure maximum therapeutic benefit. **This is our cancellation policy.**

**I have read and understand the above agreement.**

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Patient/Responsible Party Signature	Relationship	Date
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**If the patient is a minor:** I give consent for treatment of the above named minor child by Schwegel Physical Therapy, P.C. dba Alton Physical Therapy, P.C. and or its affiliated offices.

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Parent/Legal Guardian Signature	Relationship	Date
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