Compassion. Care. Respect. Integrity. Outstanding Service.

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 Umpl

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.

____

Patient/Responsible Party Signature　　　Relationship　　　Date

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.

____

Parent/Legal Guardian Signature　　　Relationship　　　Date