Patient Information

elevate Physical Therapy

First Name		Last Name		M	
Street Address					
City		State		Zip Code	
Home Phone		Cell Phone			
Work Phone		E-mail			
Date of Birth		Male ☐	Female ☐		
SS#:					
Are you interested in receiving our informative newsletter?		Yes ☐			

Emergency Contact			
First Name		Last Name	
Emergency Contact Primary Phone:			

Subscriber (Insured) Information *Please fill out if someone other than you.*					
First Name		Last Name		M	
Street Address					
City		State		Zip Code	
Relationship		Date of Birth		Male ☐	Female ☐

Worker's Comp ONLY: Employment Information			
Employer		Town/City	

Minors ONLY: Responsible Party Information					
First Name		Last Name		M	
Street Address					
City		State		Zip Code	
Phone					

Release of Authorization/Assignment of Benefits:

I authorize the release of medical information necessary to process my insurance claim(s). I authorize the request for payment of medical benefits directly to Elevate Physical Therapy, LLC. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me.

Signature:		Date	

Medical History

elevate Physical Therapy

Name:		Referring Physician:			
Primary Care Physician:		Date of Last Visit:			
Height:		Weight:		Hand Dominance:	Right ☐ Left ☐

Have you noted any of the following in the past three months (Check all that apply)?		
☐ Pain at Night	☐ Weight loss/gain	☐ Changes in Appetite
☐ Weakness/Fatigue	☐ Headaches	☐ Shortness of Breath
☐ Nausea/ Vomiting	☐ Changes in bowel or bladder function	

For Women:	Are you currently or think you might be pregnant?	Yes ☐	No ☐

Have you ever been diagnosed with any of the following (Check all that apply)?		
☐ Anemia	☐ Asthma	☐ Cancer (Please explain below)
☐ Chemical Dependency	☐ Depression	☐ Diabetes: Type I or Type II (circle)
☐ Epilepsy/Seizures	☐ Heart Disease (i.e. CHF)	☐ High Blood Pressure
☐ Kidney/Liver Disease	☐ Lung Disease	☐ Multiple Sclerosis
☐ Osteoporosis/Osteopenia	☐ Pacemaker	☐ Parkinson's Disease
☐ Rheumatoid Arthritis	☐ Stroke (CVA, TIA)	☐ Thyroid Problems
☐ Other:	☐ Other:	☐ Other:
Please use this section to explain the above further:		

Surgical History			
Please list surgeries you have had and include the dates:			
Surgery	Date	Surgery	Date
1		2	
3		4	

Current Injury or Condition:

When did your symptoms begin?

How did your symptoms begin?

In the Past 7 days, Please rate the **Best/Lowest** your pain has been: (Circle)

0	1	2	3	4	5	6	7	8	9	10
No Pain										Hospital Pain

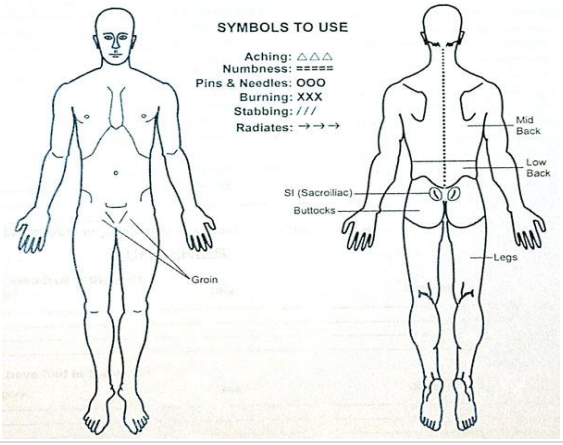
What makes your pain better?

In the Past 7 days, Please rate the **Worst/Most** your pain has been: (Circle)

0	1	2	3	4	5	6	7	8	9	10
No Pain										Hospital Pain

What makes your pain worse?

Please note where your pain is located:



Please list all current Medications: (Please include frequency and dosage)

Patient/Guardian Signature:		Date:	

Patient HIPAA Awareness

With my permission, Elevate Physical Therapy may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations.

Elevate Physical Therapy always has a copy of the Notice of Patient Information Practices available. Elevate Physical Therapy reserves the right to revise the Notice of Patient Information Practices at any time.

With my permission, Elevate Physical Therapy may call my home or other designated locations and leave a message on voicemail or in person, in reference to any item that would assist the practice in carrying out treatment, payment and healthcare operations, such as appointments reminders or insurance items.

With my permission, Elevate Physical Therapy may mail to my house or other designated locations any item that assists the practice in carrying out treatment, payment and healthcare operations, such as appointment reminder sheets, and patient statements.

With my permission, Elevate Physical Therapy may e-mail or fax myself or my physician any item that assists the practice of carrying out treatment, payment and healthcare operations, such as progress reports or plans of care.

By signing his, I am allowing Elevate Professional Services, LLC and Elevate Holding Company, LLC to use and disclose my protected health information for treatment, payment and healthcare operations. I have also been shown the Notice of Patient Information Practices and have the right to request a copy at any time.

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Patient or Legal Guardian Signature Print Name Date

Cancellation and No Show Policy

Thank you for choosing Elevate Physical Therapy to provide your physical therapy care. We are looking forward to working with you to remedy your condition. In order to accomplish this it is absolutely necessary that you attend all of your scheduled appointments.

All missed appointments must be made up the same week so you may fully recover.

Elevate Physical Therapy requires 24 hour advance notice for any cancellation. If you are unable to give 24 hour advance notice or you do not show for your scheduled appointment you will incur a $75 dollar charge.

Please be aware that your insurance company will not pay this fee, and thus is your responsibility.

This policy is not in effect in times of bad weather. We define this as days when schools are closed because of bad weather.

I understand and agree to comply with the above policy.

_____

Patient's Signature

_____

Date