



# ATLAS PHYSICAL THERAPY AND SPORTS MEDICINE, INC

## Patient information

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

Patient Name: \_\_\_\_\_ SSN# \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Home#: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: Male \_\_\_\_\_ Female \_\_\_\_\_

In case of Emergency Name: \_\_\_\_\_ Number: \_\_\_\_\_

Student Status: FT PT or Non-student. School Attending: \_\_\_\_\_

Marital Status: Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Separated \_\_\_ Widowed \_\_\_

How did you hear about us? \_\_\_\_\_

Are you employed? Yes No Occupation: \_\_\_\_\_

Employer \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Date of current illness? \_\_\_\_\_ Cause of Condition: Illness \_\_\_ Job Related \_\_\_ Auto Accident \_\_\_

WComp \_\_\_ Other \_\_\_

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

Email Address: \_\_\_\_\_

### INSURANCE INFORMATION

Primary Insurance Company \_\_\_\_\_ ID# \_\_\_\_\_

Relationship to the insured \_\_\_\_\_ Group # \_\_\_\_\_

Primary Insured Name: \_\_\_\_\_ Insured DOB: \_\_\_\_\_

Policy/Claim # \_\_\_\_\_ Phone # \_\_\_\_\_

Date of Injury \_\_\_\_\_ Adjustor's Name \_\_\_\_\_

Billing Address \_\_\_\_\_

### SECONDARY INSURANCE (OR HEALTH INSURANCE IF WCOMP/AUTO)

Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Policy/Claim # \_\_\_\_\_ Group # \_\_\_\_\_

Billing Address \_\_\_\_\_

### ALL PATIENTS AND RESPONSIBLE PARTIES PLEASE READ AND SIGN

I authorize release of any medical information necessary to process the claim. I authorize the payment of medical benefits directly to this office for services rendered. I understand that I am financially responsible for charges not covered by this authorization, except where prohibited by law. If the delinquent account is referred for collection and/or litigation, patient agrees to pay Atlas's collection agency fees, attorney's fees and court costs associated with the collection/litigation process.

Signature \_\_\_\_\_ Date \_\_\_\_\_



**CONFIDENTIAL PATIENT HEALTH HISTORY FORM**

Name \_\_\_\_\_

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

DOB \_\_\_\_\_

Height \_\_\_\_\_

Weight \_\_\_\_\_

**Please place an "X" in the space provided if you have had any of the following conditions:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Heart Disease               | <input type="checkbox"/> Colitis               | <input type="checkbox"/> Hepatitis      |
| <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Epilepsy              | <input type="checkbox"/> Pacemaker      |
| <input type="checkbox"/> Prolapsed Mitral Valve      | <input type="checkbox"/> Artificial Prosthesis | <input type="checkbox"/> Metal Implant  |
| <input type="checkbox"/> Glaucoma                    | <input type="checkbox"/> Hearing Loss          | <input type="checkbox"/> Swollen Ankles |
| <input type="checkbox"/> Tuberculosis                | <input type="checkbox"/> Pregnant              | <input type="checkbox"/> Sinusitis      |
| <input type="checkbox"/> AIDS                        | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Asthma         |
| <input type="checkbox"/> Liver Disease               | <input type="checkbox"/> Lung Disease          | <input type="checkbox"/> Cancer         |
| <input type="checkbox"/> Leukemia                    | <input type="checkbox"/> Rheumatic Fever       |   |
| <input type="checkbox"/> Ulcers                      | <input type="checkbox"/> Arthritis             |   |
| <input type="checkbox"/> Mental/Psychiatric Disorder | <input type="checkbox"/> HIV                   |   |
| <input type="checkbox"/> Stroke                      | <input type="checkbox"/> Kidney Disease        |   |
| <input type="checkbox"/> Heart Murmur                | <input type="checkbox"/> Thyroid Disease       |   |
| <input type="checkbox"/> Other _____                 |  |   |

**Please list any surgeries you have had related to your current physical therapy problem:**

\_\_\_\_\_  
\_\_\_\_\_

**Please list any previous surgeries:**

\_\_\_\_\_

**Please list any medications you take:**

\_\_\_\_\_

Who is your family Physician? \_\_\_\_\_

When was your last physical exam? \_\_\_\_\_



**CONDITIONS OF ADMISSION**

Medicare has implemented the Therapy Cap. The Cap states that Medicare will only allow \$1880 a year for 2012 for outpatient Physical and Speech language pathology services combined. For this office that is an average of 12 to 15 visits per year.

I authorize the payment of medical benefits directly to this office for services rendered. I understand that I am financially responsible for charges not covered by this authorization, except where prohibited by law.

Printed Name \_\_\_\_\_ Date \_\_\_\_\_

Patient's Signature \_\_\_\_\_

We appreciate 24 hour notification of cancellations. If there are consistent lapses in scheduled attendance, you will incur a \$30.00 fee that will be assessed to your account.

**TREATMENT CONSENT:** The patient is under the control of his physician, and undersigned consents to any treatment of procedures rendered the patient by Atlas Physical Therapy under the general and specific instructions of the physician. It is further understood that Atlas Physical Therapy is authorized to carry out all instructions of the patient's physician and that Atlas Physical therapy is hereby relieved of any and all liability occurring from the performance of the physician's instruction.

I request and authorize the staff of Atlas Physical Therapy to provide me with treatment, and to perform any procedures now contemplated or such additional procedures as my physician may deem reasonable and necessary.

I acknowledge that I have received/declined a copy of the Notice of Our Privacy Practices from the office of Atlas Physical Therapy & Sports Medicine, Inc. **Initials of Patient** \_\_\_\_\_

I understand that some of my health information may be used and/or disclosed by Atlas Physical Therapy to carry out treatment, payment, or health care operations, and that for a amore complete description of such uses and disclosures, I should refer to your privacy notice entitled, "Notice of Our Privacy Practices." I understand that I may review this privacy notice at any time prior to signing this form.

I understand that over time your privacy practices may need to change in accordance with the law and that if I wish to obtain a copy of this notice as revised, I can call your office to request such copy.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care operations and that I can also revoke this consent in writing, but only to the extent that your practice has not taken action in reliance thereon.

I understand that for my protection any requests to amend my health information or to access my medical records must be made in writing.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness (Person securing Request) \_\_\_\_\_ Date \_\_\_\_\_