Gubler's Physical Therapy

PATIENT INFORMATION FORM

Please Fill-Out Completely and Print Legibly

Name: ______________________________ DOB: ___/___ /___ Age: ______ SS#:____________________

Address: _____________________________ City: ________________ State: ______ Zip: _____________

Day Phone: ______________ Evening Phone: ________________ E-mail: _________________________

Occupation: ______________ Employer: ____________________ Referring Doctor: __________________

In Case of Emergency,
Contact: Name: _____________________ Relationship: ______________ Phone: _____________________

Responsible Party (if not patient)
Name________________________________DOB______________________SS#__________________
Mailing Address____Home Phone#______________

Method of Payment

❑ Workers Comp. ❑ Private Insurance/HMO ❑ Medicare ❑ Self-pay ❑ Other

Is there a Date of Injury related to this claim: Yes No If yes, provide date: _____/_____/_____

Is there a Claim Number: Yes No If yes, the #: ___________________ Insurance Co: ____________________

Are You Currently Seeing a Chiropractor: Yes No Do you have a lawyer for this claim: Yes No

Previous Treatment

Have you received previous treatment for this condition? Yes No If yes, please complete the following:

☐ **Medicines** ☐ **Injections** ☐ **Surgery** ☐ **Chiropractic** ☐ **Physical Therapy** ☐ **Other**

Medical & Health Information

Height: ___ ft. _____ in. Weight: ______ lb. Cigarettes Yes No Hand Dominance (circle): Right Left Ambi

Have You Ever Had the Following Diagnoses (circle): Heart Disease High Blood Pressure Other Cardiovascular Disease Lung Disease Diabetes Cancer Rhematoid Arthritis Other Arthritis Neurological Disease Stroke Endocrine Disease Fibromyalgia Chronic Fatigue Syndrome

Other ____

Have You Ever Had Surgery: Yes No (If Yes, list procedure and year): ___________________________________

____

Describe Your General Health (circle): Excellent Good Fair Poor If poor, explain: ____________________

Have You Had Any Unexplained Weight Loss (> 10 lb.) Recently (past 6 months): Yes No
What Prescription Medications Do You Take (list): ____

____

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Turn Over & Complete

Special Questions

Since your problem started have you experienced any of the following difficulties, or any other unusual signs or symptoms (list below table):

❑ Loss of control over the function of your bowel or bladder	❑ Loss of control over your balance and equilibrium	❑ Loss of control of the ability to move your feet, toes or legs.
❑ Loss of feeling of any part of your body.	❑ Severe headaches, nausea/vomiting, fever or disorientation.	❑ Other (describe below)

Other: ____

____

Do you exercise daily: yes no If yes, briefly describe: ____________________________________

____

What is your goal or reason for coming to physical therapy (describe briefly): ______________________

____

AUTHORIZATIONS/ACKNOWLEDGEMENTS

Consent For Treatment and Authorization to Release

Information: I hereby authorize Gubler's Physical Therapy, (GPT) through its appropriate personnel to perform or have performed upon the above named patient, appropriate assessment and treatment procedures or me. I further authorize GPT to release to appropriate agencies any information acquired in the course of my examination and treatment.
Payment Authorization: I authorize and request my insurance company to pay directly to Gubler's Physical Therapy, group insurance benefits otherwise payable to me.

X ______________________ ___ / ___ / ____ X ______________________ ___ / ___ / ____
Signature of patient Date Witness Date

ACKNOWLEDGEMENT OF RECEIPT OF GPT's NOTICE OF PRIVACY PRACTICES

Effective as of Date Indicated Below

By signing below I acknowledge that Gubler's Physical Therapy, has given me a copy of its notice of Privacy Practices.

Patient Signature:______________________ Print Name:______________________ Date: __________

PRIVATE PATIENT PAYMENT AGREEMENT

Thank you for selecting our healthcare team. We will strive to provide you with the best possible treatment. If you have questions about your insurance don't hesitate to ask (635-9333). Your health insurance policy may require you to pay a deductible or co-payments for each physical therapy visit. Your insurer sets the amount, so if you have questions about it please contact them. Co-payments are due at the time of service, however if you want to be billed, please inform our receptionist. In addition to co-payments, your insurer may not cover the cost of physical therapy supplies (lumbar and cervical rolls, splints, etc.). If you are given supplies that are not covered we request that you pay for them at the time they are given. Some insurers require pre-authorization. If pre-authorization is required, it is your responsibility to make sure that your referring physician has called in a referral to your insurer prior to starting physical therapy. If this is not done you may be billed for unauthorized visits. **Collections:** We make every effort to avoid undue hardship in settling unpaid debt, however if your account is delinquent more than 30 days and you have not made payment arrangements with our billing department (435-635-9333), your account will be turned over to an outside collections agency, at which time up to 40% may be added for collections, and any attorney fees may be added. A finance charge of 1.5% per month (annual of 18%) will be charged on all balances over 30 days regardless of pending insurance claims

I have read the above information and agree: Patient Signature: ______________________ Date: __________

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