

INSURANCE COVERAGE INFORMATION:

Are you **presently** receiving home care services (therapy, nursing, home health aide)? Yes No

Have you **recently** received home care services, (therapy, nursing, home health aide)? Yes No

If yes, discharge date: _____ Name of Agency: _____

CONSENT TO TREATMENT: I consent to rehabilitation and related services at HPTS. In so doing, I understand, acknowledge, and affirm that such rehabilitation and related services may involve bodily contact, touching, and/or direct contact of a sensitive nature.

Initial _____

TREATMENT OF MINORS: I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so.

Initial _____

LIABILITY: I agree that HPTS is not responsible for loss or damage to personal valuables.

Initial _____

WAIVER AND RELEASE: I hereby release, discharge and acquit HPTS, it's agents, representatives, affiliates, employees, or assigns of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind, arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services, including but not limited to ambulance service, Emergency Medical Technician, physician, or urgent care services.

Initial _____

AUTHORIZATION OF PAYMENT: I hereby assign all benefits directly to HPTS and also authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment. I understand that if my account is sent to collections, the additional charges of up to 35% of billed charges will be added to my account for collection services.

Initial _____

NOTICE OF PRIVACY: I acknowledge receipt of Notice of Privacy Practices.

Initial _____

I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature _____ Date _____

Witness Signature _____

HAMILTON PHYSICAL THERAPY SERVICES, L.P.

PATIENT NAME: _____

DATE: _____

MEDICAL HISTORY

Have you ever had: Heart Disease: Y N High Blood Pressure: Y N Cancer: Y N

Diabetes: Y N Are you Pregnant: Y N Taking Steroid Meds: Y N

Please explain any "YES" answers: _____

Any Relevant Surgical Procedures and Dates: _____

Present Medications: _____

Date of Next Physician's Visit _____

CURRENT HISTORY

Briefly describe your symptoms: _____

Have you ever had physical therapy for THIS injury/illness before: Y N

If "YES", where/when and what was the outcome: _____

REFERRAL – How did you choose HPTS?

Physician

Friend or Relative of patient

Employer

Advertisement

Former Patient

Insurance

Insurance

Yellow Pages

Internet

Other _____

Patient Signature _____ Therapist Signature _____

HAMILTON PHYSICAL THERAPY SERVICES, L.P.

PATIENT NAME: _____

DATE: _____

GENERAL PROFILE

Do you participate in any sports: (recreational or organized) Y N

If "YES" please circle which ones: Golf Basketball Tennis Football Running
Walking Baseball/Softball Soccer Aerobics

Are you currently unable to participate in any sports above due to illness/injury: Y N

If "YES" please explain: _____

Any other information your physical therapist should know: _____

WORK HISTORY

Job Title: _____

Employer: _____

Please briefly describe the main duties on your job, i.e. lifting, carrying, computer work, etc.

**ARE YOU CURRENTLY OUT OF WORK DUE TO THIS INJURY/ILLNESS: YES NO
RESTRICTED DUTY: YES NO (IF "NO" TO BOTH PROCEED TO LAST QUESTION)**

Last Day Worked _____

What presently is keeping you from returning to work: _____

Do you have a return to work date from your doctor: Yes No if "Yes", when: _____

Any other information your physical therapist should know: _____

THANK YOU!