

PATIENT INFORMATION FORM

(Please print and complete ALL items, if an item doesn't apply, put N/A)

Patient Name: last first middle Age:

Address: street city state zip

Home Phone: Cell Phone: Marital Status:

Social Security #: Sex: Date of Birth:

Employer: Occupation: Work Phone:

Referring Doctor: Phone: Next Dr. Appt.

E-Mail Address:

Who will be primarily responsible for the bill?

Person to notify in case of emergency OUTSIDE of household: (Relationship)

Name: Home Phone: Work Phone:

Address: street city state zip

* PRIMARY Insurance Company: Phone #:

ID# Group# (if any)

If not the patient:

Policy Holder's Name: last first middle

Policy Holder's Social Security #: Date of Birth:

Policy Holder's Employer: Phone:

Employer's Address: street city state zip

** SECONDARY Insurance Company: Phone #:

ID# Group# (if any)

If not the patient:

Policy Holder's Name: last first middle

Policy Holder's Social Security #: Date of Birth:

Policy Holder's Employer: Phone:

Employer's Address: street city state zip

I hereby authorize Excellent Choice Physical Therapy, Inc. to furnish information to the insurance carriers concerning my treatment and hereby assign to the therapist(s) all payments for service rendered. I understand that I am responsible for all charges, even those not paid by my insurance. I understand that by signing I am giving my permission for treatment. I also authorize Excellent Choice Physical Therapy, Inc. to contact the insurance commissioner on my behalf, to assist me in receiving my full insurance benefits, if deemed necessary.

SIGNATURE: DATE:

Patient Health Questionnaire - PHQ

Form PHQ-202

Health Plan Use Only rev 7/18/05

Patient Name _____ Date _____

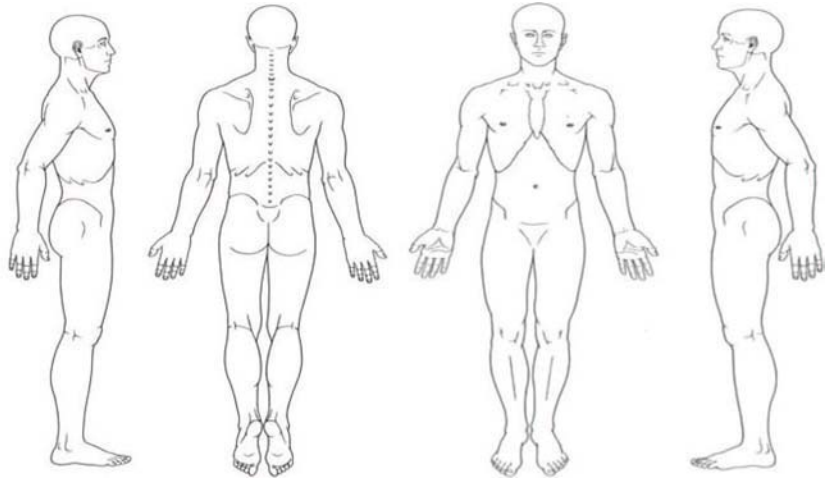
1. Describe your symptoms

a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms? Indicate where you have pain or other symptoms

- ① Constantly (76-100% of the day)
- ② Frequently (51-75% of the day)
- ③ Occasionally (26-50% of the day)
- ④ Intermittently (0-25% of the day)



3. What describes the nature of your symptoms?

- ① Sharp
- ② Dull ache
- ③ Numb
- ④ Shooting
- ⑤ Burning
- ⑥ Tingling

4. How are your symptoms changing?

- ① Getting Better
- ② Not Changing
- ③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?

(like visiting with friends, relatives, etc)Plan

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

8. Who have you seen for your symptoms?

- ① No One
- ② Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

- ① Xrays date: _____
- ② MRI date: _____
- ③ CT Scan date: _____
- ④ Other date: _____

9. Have you had similar symptoms in the past?

- ① Yes
- ② No
- ③ This Office
- ④ Chiropractor
- ⑤ Medical Doctor
- ⑥ Physical Therapist
- ⑦ Other

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

10. What is your occupation?

- ① Professional/Executive
- ② White Collar/Secretarial
- ③ Tradesperson
- ④ Laborer
- ⑤ Homemaker
- ⑥ FT Student
- ⑦ Retired
- ⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

- ① Full-time
- ② Part-time
- ③ Self-employed
- ④ Unemployed
- ⑤ Off work
- ⑥ Other

Patient Signature _____ Date _____

Excellent Choice Physical Therapy, P.C.

Name _____

Date: _____

ASSIGNMENT AUTHORIZATION AND INSTRUCTION FOR DIRECT PAYMENT TO THERAPIST: PRIVATE, GROUP, ACCIDENT AND HEALTH INSURANCE

I hereby authorize and direct my **Insurance Carrier** to pay by check made out and mailed directly to the above mentioned office. If my policy prohibits direct payment to my therapist, then I hereby instruct and direct the check to be made to me and mailed to the above mentioned office. The professional or medical expense benefits allowable and otherwise payable to me under my current policy as payment toward total charges for professional services rendered. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in current manner, any balance of said professional service charges over and above the insurance payment. I also authorize the release of any information pertinent to my case to any insurance carrier, adjuster or attorney involved in this case.

X _____
SIGNATURE OF POLICYHOLDER

* BY SIGNING ABOVE, THE CO-INSURANCE AND
CO-PAYMENT OF MY PHYSICAL THERAPY BENEFITS
WOULD BE A FINANCIAL HARDHIP ON ME

GUARANTEE AGREEMENT

- In consideration of services rendered by **Excellent Choice P.T.** to the undersigned patient, the undersigned promise(s) to pay **Excellent Choice** any co-payment, coinsurance or other charges required to be paid by my health insurance coverage. In addition, I promise to pay for all services that are not covered by my health insurance plan provided I am informed of the same prior to the rendering of said services.
- I hereby assign to **Excellent Choice P.T.** all monies and/or benefits to which I am entitled from my insurer/HMO/third-party payer, government agencies, or those who are financially liable for my medical care.
- I hereby authorize **Excellent Choice P.T.** to release to my insurer/HMO/third-party payer, governmental agencies, or to whomever is financially responsible for my medical care, all information needed to substantiate payment for such medical care and, if required, for pre-certification/prior approval purposes. It is, however, expressly understood that there will be no obligation of the undersigned to pay for any services, other than those services covered by Paragraph I above, which are not "medically necessary" or improperly billed.

X _____
SIGNATURE OF POLICYHOLDER

MISSED APPOINTMENT POLICY:

With the exception of serious emergencies, **it is expected that you keep all your appointments.** If you need to re-schedule an appointment, we require a **24 hour notice.** In such a case, please call our office and arrange for a make-up appointment with our Front Desk Receptionist. The make-up appointment needs to be in the same week, preferably the **very next** day. In an instance of a cancellation without 24 hours notice or no-show to a scheduled appointment, we reserve the right to charge/bill you a **fee of \$50.00.** In repeated non-compliance with your scheduled visits, we reserve the right to discontinue care and will inform your physician.

X _____
SIGNATURE OF POLICYHOLDER

PATIENT'S PRIVACY STATEMENT: (HIPPA)

I, _____, hereby acknowledge that I have been given the opportunity to review or, if requested, have received a copy of this practice's **Notice of Privacy Practices.** I have been given the opportunity to ask any questions I may have regarding this Notice.

X _____
SIGNATURE OF POLICYHOLDER