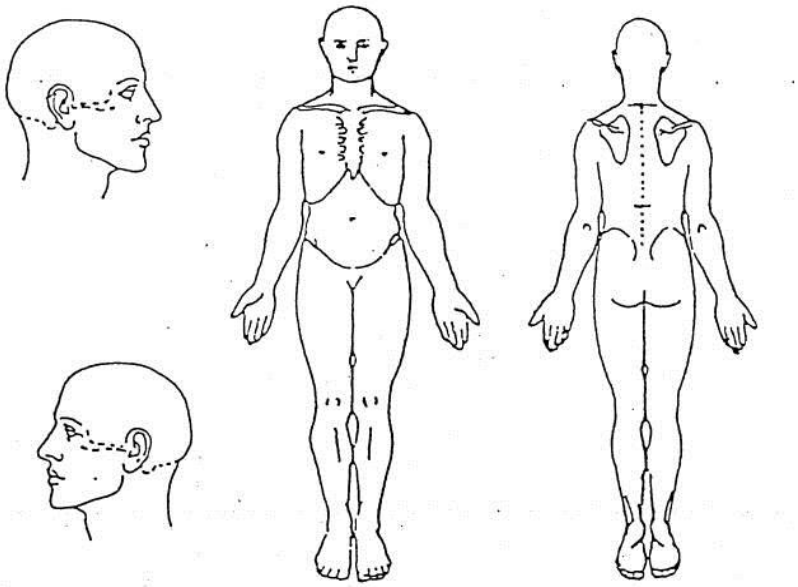
PRECISION PHYSICAL THERAPY **CONFIDENTIAL**

MEDICAL HISTORY FORM

Name _____ Date _____

Birth date_____ Email _____

Please mark the appropriate area of the diagram to show the location of your current symptoms:



Please describe your current symptoms:

Date of injury/surgery: _ _ / _ _ / _ _ _ _
(Month / day / year)

How did your symptoms begin?

Have you used any other forms of treatment for your current problem: (i.e. chiropractor, PT, acupuncture, etc.)?

Please List <u>All</u> Orthopedic or Abdominal Operations/Surgeries:

Operation Performed	Year
_____	_____
_____	_____
_____	_____
_____	_____

List the medications you are now taking:

List any special tests you have had for this condition: (X-rays, MRI, CT scan, etc.):

List any allergies you have to drugs, food or other items (including latex):

Pain Level: (0 being none and 10 being the worst)

0 1 2 3 4 5 6 7 8 9 10

What makes your symptoms feel better? _____

What makes your symptoms feel worse? _____

What is your general overall health? Poor Fair Good Excellent

Stress Level: (0 being none and 10 being the worst)

0 1 2 3 4 5 6 7 8 9 10

Do you exercise? Yes No

- **If yes, what type of exercise? _____**
    - **How often? _____**

Have you had any of the following illnesses: (Please Circle)

High Blood Pressure	Multiple Chemical Sensitivity	Adrenal Fatigue
Diabetes (type I or II)	Candida (yeast allergy)	Restless Leg Syndrome
Thyroid Dysfunction	Eating Disorder	Pacemaker
High Cholesterol	Celiac Disease	Headaches, if yes, how often?
Heart Attack/Disease	Migraine Headaches	Osteoporosis
Asthma	Alcoholism	Osteopenia
Pulmonary Diseases	Anxiety	Chronic Pain
Stroke	Sleep Disorders	Fibromyalgia
Brain injury	Irritable Bowel Syndrome	Interstitial Cystitis
Blood clots	Ulcers	Chronic Pelvic Pain
Mental Illness/Depression	PTSD	Dysautonomia
Arthritis	Crohn's Disease	Sensory Processing Disorder
Cancer	Elevated Heart Rate	Other serious illnesses: (Please Explain):

_____ _____

Signature (parent/guardian signature if patient is a minor) **Date**

Precision Physical Therapy, Inc.

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13150 W 72nd Avenue Arvada, CO 80005
www.precisionphysicaltherapy.net
303-926-1444 (phone) 303-926-0038 (fax)

Full Name:		DOB: ___/___/_____	SSN:
Address:		City/State:	Zip:
Phone: (home)	(cell)	(work)	
Email Address:			Sex: M/F
Referred by:		Referring Physician Phone:	
Address:		City/State:	Zip:
Primary Care Doctor:		Office Phone:	
Address:		City/State:	Zip:
Emergency Contact Info	Name:	Contact Number:	

Primary Insurance

Primary Insurance Plan:	Policy Holder Name:
ID Number:	Relationship to Patient:
Group Number:	Policy Holder Date of Birth:

Secondary Insurance

Secondary Insurance Plan:	Policy Holder Name:
ID Number:	Relationship to Patient:
Group Number:	Policy Holder Date of Birth:

Condition Information

Is your condition due to an accident?	Date of Accident:	
Type of Accident: Auto/Work/Home	If other, please qualify:	
Did you file a claim? Y/N	Adjuster's Name: Claim #:	Adjuster's Contact Number:

Patient Name:	Date of Birth:

Consent to Treat

I authorize *Precision Physical Therapy* to render services as deemed necessary for the care of the above named Patient.

For Minors Only:

I **do** [ ] / **do not** [ ] allow the above named Patient to be treated by *Precision Physical Therapy* without a Guardian being present.
Responsible Party Name: _____ Responsible Party Signature: _____

Assignment of Medical Insurance Benefits

Thank you for choosing *Precision Physical Therapy*. We will work with you to help you with your insurance claims, but would like you to understand our office policy regarding insurance assignment.

Payment is expected at the time of service unless we accept assignment with your insurance company or previous payment arrangements have been made. For our office to accept insurance assignment, we ask that you read and sign the following.

I acknowledge that it is my responsibility to:

1. Provide complete up-to-date information on medical insurance coverage for the patient.
2. Present a valid insurance card when requested.
3. Pay applicable copayment at the time of service.
4. Present a valid referral or authorization number for all services (if required by my insurance company).
5. Inform the office if the patient's need for medical services is due to a motor vehicle, worker's compensation or other accident.
6. Make payment within 30 days any balance on my account for any amount due such as deductibles, coinsurance, co-payments, or non-covered services.

Payment Policy

I am ultimately responsible to pay the medical bill if my insurance company does not honor the assignment of benefits in whole or in part. Payments may be arranged. I agree that if it becomes necessary to forward my account to a collection agency, I will also be responsible for the reasonable cost of collection, to include any attorney fees.

Your signature below indicates:

1. You read and understand the Acknowledgement of receipt of Notice of Privacy Practices
2. You understand and agree to the Consent to Treat
3. You understand and accept our policy of assignment of insurance benefits.
4. You attest to the accuracy and completeness of the medical insurance coverage information.
5. You authorize this office to release medical information necessary to process your claims and appeals.
6. You authorize payment of medical benefits to *Precision Physical Therapy*.
7. You have read and understand the Payment Policy.

Patient or Responsible Party Signature:	Date Signed:
(Responsible Party, Relationship to patient):	

Precision Physical Therapy

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: ____ **Patient ID #:** _______________________

I hereby acknowledge that I have received a copy of Precision Physical Therapy's Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

____

Signature of Patient or Legal Representative

____

Date

____

Printed Name of Patient's Representative (*if applicable*)

Relationship to Patient (*if applicable*)

- ☐ Parent or guardian of unemancipated minor
- ☐ Court appointed guardian
- ☐ Executor or administrator of decedent's estate
- ☐ Power of Attorney

- -

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices on the following date,

_____________________________ but acknowledgment could not be obtained because:

- ☐ Patient/representative refused to sign
- ☐ Emergency situation prevented us from obtaining acknowledgement at this time (will attempt again at a later date)
- ☐ Communication barriers prohibited obtaining acknowledgement (Explain)

____

____

____

____

____

- ☐ Other (Specify)

____

____

____

____

____

Cancellation Policy/No Show Policy for Precision Physical Therapy

Our goal is to provide quality medical care in a timely manner. To do so we have implemented a cancellation/no show policy. This policy enables us to better utilize available appointments for our patients in need of medical care.

1. **Cancellation/ No Show Policy**
   We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel, and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. If an appointment is not cancelled at least 4 hours in advance you will be charged a seventy-dollar ($70) fee; **this fee will not be covered by your insurance company.**

   How to Cancel Your Appointment
   If it is necessary to cancel your scheduled appointment, we require that you call at least four hours prior to your scheduled appointment time. Appointments are in high demand, and your early cancellation will give another patient the opportunity to have access to timely medical care. To cancel an appointment, please call our office at (303) 926-1444.

2. **Scheduled Appointments**
   We understand that delays can happen however we must try to keep the other patients and our therapists on time. If a patient is 15 minutes past their scheduled time we may have to reschedule the appointment, and you will be charged a seventy-dollar ($70) fee.

3. **Reminder Calls or Texts**
   We offer free reminder calls or text messaging for all appointments.

   I would like to receive reminder:
   ☐ **TEXTS**

   ☐ **CALLS**

PRINT Patient Name: _____

Signature: _____ Date: _____
(Parent/Guardian if patient is a minor)

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