



6701 W. Blondell St. Wasilla, AK 99654

Dear Valued Patient:

Thank you for choosing First Choice Physical Therapy for your therapy services. We strive to provide the best care for our patients. The staff will assist you with any area of need. Please do not hesitate to ask for assistance at anytime if you do not understand something.

There is a time on our schedule reserved especially for you and it is important that you be on time for your appointments. If you can't make an appointment, we request advanced notification of 24 hours. This will allow us to provide another patient with the opportunity to come in at that appointment time. Please be aware that after 3 "No Shows" we reserve the right to discharge you from our services. Please do not allow it to come to this. Our goal is to get you better and look forward to serving you. If "something comes up" please just give us a courtesy call and we will happily get you rescheduled to come in at a more convenient time.

Thank you for your time and cooperation in getting you back to better health! ☺

I have read and understand the above request.

Signature

Date



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Today's Date:

PCP:

PATIENT INFORMATION

Patient's last name: First: Middle: Marital status: Is this your legal name? Birth date: Age: Sex: Physical address: Social Security no.: Home phone no.: P.O. box: City: State: ZIP Code: Occupation: Employer: Employer phone no.: Chose clinic because/referred to clinic by: Other family members seen here:

INSURANCE INFORMATION

(Please give your ID and insurance card to the receptionist.)

Person responsible for bill: Birth date: Address (if different): Home phone no.: Is this person a patient here? Occupation: Employer: Employer address: Employer phone no.: Is this patient covered by insurance? Please indicate primary insurance: Subscriber's name: Subscriber's S.S. no.: Birth date: Group no.: Policy no.: Co-payment: Patient's relationship to subscriber: Name of secondary insurance (if applicable): Subscriber's name: Group no.: Policy no.: Patient's relationship to subscriber:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): Relationship to patient: Home phone no.: Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to First Choice Physical Therapy. I understand that I am financially responsible for any balance. I also authorize First Choice Physical Therapy or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date



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PATIENT MEDICAL HISTORY

Name: _____ Referring Physician: _____

Family Physician: _____ Date of 1st Dr. Visit for this injury: _____

Returned to Work after this injury: Yes No If yes, Date: _____

Is an attorney involved in this case? Yes No

Occupation: _____ Have you had surgery for this injury? Yes No

Number of surgeries: 1 2 3 4 Other Type of Surgery: _____

Are you currently taking any prescription or non-prescription medications? Yes No

Anti-Inflammatories Yes No
 Muscle Relaxers Yes No
 Pain Medication Yes No

List Medications: _____

Have you had any of the following medical or rehabilitative services for this injury?

| | | | |
|----------------------|--|----------------------|--|
| Chiropractor | <input type="checkbox"/> Yes <input type="checkbox"/> No | CT Scan | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| EMG/NCS | <input type="checkbox"/> Yes <input type="checkbox"/> No | General Practitioner | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Massage Therapy | <input type="checkbox"/> Yes <input type="checkbox"/> No | MRI | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Myelogram | <input type="checkbox"/> Yes <input type="checkbox"/> No | Neurologist | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Occupational Therapy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Orthopedist | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Physical Therapy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Podiatrist | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emergency Room Care | <input type="checkbox"/> Yes <input type="checkbox"/> No | X-Rays | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Other: _____

Do you now have or have you ever had any of the following? Please check Yes or No.

| | | | |
|----------------------------------|--|---------------------------|--|
| Asthma, Bronchitis, or Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No | Weight Loss | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Shortness of Breath/Chest Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Energy Loss | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Coronary Heart Disease or Angina | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hernia | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have a pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Allergies | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Attack or Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | Implants | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Stroke/TIA | <input type="checkbox"/> Yes <input type="checkbox"/> No | Joint Replacement | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Clot/Emboli | <input type="checkbox"/> Yes <input type="checkbox"/> No | Neck Injury/Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Epilepsy/Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shoulder Injury/Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Thyroid/Goiter | <input type="checkbox"/> Yes <input type="checkbox"/> No | Elbow/Hand Injury/Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Back Injury/Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No |



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PATIENT MEDICAL HISTORY CONTINUED

| | | | | | |
|----------------------------------|------------------------------|-----------------------------|-------------------------------|------------------------------|-----------------------------|
| Infectious Diseases | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Knee Injury/Surgery | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Leg/Ankle/Foot Injury/Surgery | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cancer or Chemotherapy/Radiation | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hearing Difficulties | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Arthritis/Swollen Joints | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Numbness | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Osteoporosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tingling | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Gout | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Dizziness | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sleeping Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Fainting | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Emotional/Psychological Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Headaches | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bowel or Bladder Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Weakness | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are you pregnant | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you smoke | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Other information that will assist us in your care: _____

Are you aware of what your diagnosis is? Yes No

What are your expectations/goals while in this program? _____

Patient/Guardian Signature: _____

Date: _____

Therapist Signature: _____

Date: _____



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CONSENT FOR CARE & TREATMENT

I, the undersigned, do hereby agree and give my consent for First Choice Physical Therapy to furnish medical care and treatment to _____ considered necessary and proper in diagnosing or treating his/her physical and mental condition.

Patient/Guardian/Responsible Party _____ Date _____

FINANCIAL POLICY STATEMENT

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when services are rendered. We require that arrangement for payment of your estimated portion be made today. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your company establishes an internal usual and customary fee schedule, you will be responsible for the difference remaining. If any payment is made directly to you for services billed by us, you recognize an obligation to promptly submit same payment to First Choice Physical Therapy.

The above may not apply for those patients that are considered Worker's Compensation or who have benefits with a balance billing contract, such as an HMO. However, be advised if you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

First Choice Physical Therapy verifies benefits as a courtesy to you. However, First Choice Physical Therapy does NOT accept responsibility for any incorrect information given by your insurance carrier regarding your co-pay/co-insurance benefits or benefit plans.

If payment is made by check and the check comes back as NSF (non sufficient funds) you are then responsible to pay us the amount of the check plus a \$25.00 returned check fee. From that point forward you will be required to pay by cash or credit card.

I understand and agree that if I fail to pay any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

Patient/Guardian/Responsible Party

Date

Center Representative/Witness

Date



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MEDICARE SECONDARY PAYOR QUESTIONNAIRE

IMPORTANT NOTICE TO MEDICARE PATIENT: Please fill out this entire form. Failure to do so may result in payment delay.

Patient Name: _____ Date: _____

Medicare Number: _____

1. If you have received Home Health Care in the past 60 days, please provide the name and phone number of the Home Health Care Service:

Not Applicable: (Proceed to next question)

Home Health Care Service Name: _____

Home Health Care Service Phone Number: _____

2. If you are entitled to benefits under a Black Lung Program, Department of Veteran Affairs or any other government program, please provide the name, address and phone number of that program.

Not Applicable: (Proceed to next question)

Program Name: _____

Program Address: _____

Program City, State & Zip: _____

Program Phone Number: _____

THIS GOVERNMENT PROGRAM LISTED IS PRIMARY AND MEDICARE IS SECONDARY

3. Was your illness/injury due to any of the following:

Not Applicable (Proceed to next question)

Work-Related Accident Date: _____

Automobile Accident Accident Date: _____

Accident on Property (other than your own)
(example: store, restaurant, etc)



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Patient Name: _____

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Question 3 continued

Please give details of the accident: _____

Please provide the name, address and contact information of the liability insurance:

Insurance Name: _____

Insurance Address: _____

Insurance City, State and Zip: _____

Insurance Phone Number: _____

Insurance Contact Name: _____

Insurance Claim Number: _____

Medicare regulations require us to file with the liability insurance first, even if they will not pay directly or immediately. We must comply with this regulation before filing. Medicare and First Choice Physical Therapy appreciate your cooperation.

4. Do you feel you have a right to be compensated by a party who may have caused the injury or illness?

No (Proceed to next question) Yes (Continue below)

If yes, do you intend to file a liability claim or lawsuit in connection with this injury or illness?

No (Proceed to next question) Yes (Continue below)

If yes, please provide the attorney information below:

Attorney Name: _____

Name of Law Firm: _____

Law Firm Address: _____

Law Firm City, State and Zip: _____



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Patient Name: _____
Question 4 Continued

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Law Firm Phone Number: _____

Do you authorize First Choice Physical Therapy to release your medical records to the above attorney and/or law firm that are related to the treatment you will be receiving at our facility for your injury/illness?

Yes No

Patient Signature: _____ Date: _____

5. If you have received a kidney transplant or are currently receiving dialysis for End Stage Renal Disease (ESRD), please provide the date of the transplant or start of dialysis:

Date: _____

6. Are you or your spouse currently employed?

Patient: Yes No

Does the employer employ more than 100 employees? Yes No

Date of retirement: ____/____/____

Never Employed

Spouse: Yes No

Does the employer employ more than 100 employees? Yes No

Date of retirement: ____/____/____

Never Employed

If NO was answered to both parts of this question, Medicare is primary.

7. If none of the above applies to you and your Medicare coverage is due to age or disability, do you have group insurance coverage through another family member's current employer?

Yes—the group insurance is primary
 No—Medicare is primary



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Patient Name: _____

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8. Do you have any benefits through TriCare/Champus?

Yes No

9. If you answered yes to questions 6, 7 or 8, please provide the group insurance information for proper billing of your account:

Insurance Name: _____

Insurance Address: _____

Insurance City, State and Zip: _____

Insurance Phone Number: _____

Employer: _____

Insured's Name: _____

Policy Identification Number: _____

Group Identification Number: _____

Patient's Signature: _____

Date: _____

THANK YOU FOR YOUR COOPERATION! ©



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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

First Choice Physical Therapy will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other healthcare operations. Healthcare operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies about your personal health information. The terms of the notice may change with time and we will always post the current notice at our facility and have copies available for distribution.

I, _____, have received a copy of First Choice Physical Therapy's Notice of Privacy Practices.

Please Print Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but the acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify) _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT
Original completed consent to be filed in patient's medical record