



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: _____ Mr. Miss Mrs. Ms. Marital status: _____
 Single Mar Div Sep Wid

Is this your legal name? Yes No If not, what is your legal name? (Former name): _____ Birth date: _____ Age: _____ Sex: _____
 M F

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 (Please check one box): Dr. Insurance plan Hospital
 Family Friend Close to home/work Yellow Pages Other

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.: _____
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Is this person a patient here? Yes No

Occupation: _____ Employer: _____ Employer address: _____ Employer phone no.: _____
 ()

Is this patient covered by insurance? Yes No

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: Self Spouse Child Other

Name of secondary insurance (if applicable): _____ Subscriber's name: _____ Group no.: _____ Policy no.: _____

Patient's relationship to subscriber: Self Spouse Child Other

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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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