sundance
physical therapy, inc.

First Name _____ Last Name _____ Social Security or Drivers License # _____

Date of Birth _____/_____/_____ Age _____ Sex M | F Marital Status S | M | W | D Occupation _____

Address _____ Apt / Unit _____ City _____ State _____ Zip _____

Phone #1: ○Mobile ○Home ○Work Phone #2: ○Mobile ○Home ○Work E-mail _____

Responsible Party (if different than patient): _____
Name Phone Date of Birth

In Case of Emergency: _____
Notify Phone

Billing Correspondence: Receive monthly billing statements via E-mail? ○Yes ○No

Appointment Reminders: ○via E-mail ○via Text Provide carrier name _____

How were you referred to us? _____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby instruct and direct my insurance company to pay by check, made out and mailed to **Sundance Physical Therapy, Inc.**, the professional and medical expense benefit allowable under my current insurance policy for services rendered to me or my dependent. This is a direct assignment of my rights and benefits under this policy. A photocopy of this Agreement shall be considered as effective and valid as the original. **I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered.** I certify the above information is true and correct to the best of my knowledge. I will notify you of any changes in the above information.

Signature of Subscriber/Beneficiary: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The Sundance Physical Therapy, Inc. Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. In addition to the copy we are providing you, copies of the current notice are available on our website at www.sundancept.com.

I acknowledge that I have received the Notice of Privacy Practices.

Print Name _____ Signature _____ Date _____

Office Use Only

○ *Patient declined to sign* ○ *Communication barriers prohibited obtaining the acknowledgement* ○ *Other:* _____

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MEDICARE PATIENTS

Initial

Have you received any Physical Therapy or Speech Therapy since January 1, 2017? ○ No ○ Yes

You have an annual limit of $1980. You may qualify for an exception to this cap, which your therapist can discuss with you. _____

Are you currently (or within the last 60 days) receiving Home Health Care through Medicare?

○ No ○ Yes If yes, what is the date you were discharged? _____

Medicare does not pay for physical therapy if you are receiving **home health services of any kind** through a home health agency. If you begin receiving home health care, you must let us know immediately. If you fail to inform us, you will be responsible to pay for any visits denied by Medicare. _____

PRIVATE INSURANCE PATIENTS

Initial

As a courtesy, we will report to you your **estimated deductible and co-payment amounts** from the information received from your insurance carrier. Information we receive from your insurance carrier regarding your coverage is NOT a guarantee of benefits or payment. **Your insurance plan is your responsibility**, so we encourage you to contact your insurance carrier regarding your benefits. _____

Co-pays, co-insurance amounts, and deductible payments are **due on the date of service upon arrival**. If you need to make special arrangements regarding payments, please speak to the office manager. _____

If we are not contracted with your insurance, you may directly receive payments for our services attached to your Explanation of Benefits (EOB). If this occurs, it is your responsibility to provide copies of the EOB (by fax, email, or mail), and forward the payment to Sundance Physical Therapy. If these are not received, you will be responsible for the full amount billed for your visit. _____

ACCIDENT / MEDICAL LIEN PATIENTS

○ Accident: Date of Injury _____ ○ Attorney: Yes | No

_____

Name of Insurance Company Claim Number Adjuster

_____

Attorney Phone Fax

_____

Address City State Zip

ADDITIONAL FEES – NOT BILLABLE TO INSURANCE

Initial

CANCELLATION/NO SHOW FEE: When you schedule for an appointment, you are reserving the time of your therapist and the resources needed for your treatment. If you need to cancel an appointment, **please do so by 4pm the business day before your appointment** (for Monday appointments, notice must be received by Friday 4pm). This allows us time to fill the opening made by your cancellation. If proper notice is not given, a cancellation fee of $75 will apply, regardless of the reason. **This fee is your responsibility, and not a reimbursable expense by insurance companies.** _____

RECORD COPY FEE: Any patient request for a copy of records must be written and signed. There is a $15 charge. _____

ELECTRICAL STIMULATION PADS: Most insurance do not allow for payment of electrical stimulation pads. There is a one-time fee of $10 if you receive electrical stimulation as a part of your treatment plan. _____

By signing below, I agree that I have reviewed and understand the information above.

_____ _____

Patient Signature Date

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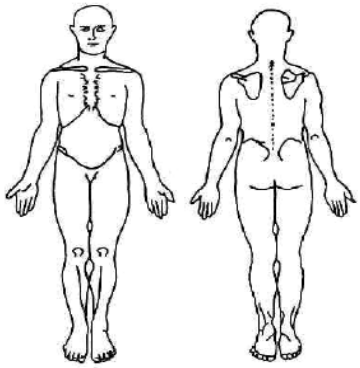
MEDICAL HISTORY

	YES	NO		YES	NO		YES	NO
Allergies	○	○	Fibromyalgia	○	○	Metal Implants	○	○
Alzheimer's	○	○	Hepatitis	○	○	Multiple Sclerosis	○	○
Anemia	○	○	High Blood Pressure	○	○	Muscular Dystrophy	○	○
Asthma	○	○	High Cholesterol	○	○	Obesity	○	○
Cardiovascular Disease	○	○	HIV/AIDS	○	○	Osteoarthritis	○	○
Cardiac Pacemaker	○	○	History of Cancer	○	○	Osteoporosis	○	○
Cauda Equina Syndrome	○	○	Huntington's	○	○	Parkinson's	○	○
Cerebral Vascular Accident	○	○	Immunosuppression	○	○	Rheumatoid Arthritis	○	○
Circulation Problems	○	○	Incontinence	○	○	Thyroid Disease	○	○
Currently Pregnant	○	○	Kidney Problems	○	○	Traumatic Brain Injury	○	○
Diabetes Mellitus: 1 or 2	○	○	Lupus	○	○	Tuberculosis	○	○

In the past 3 Months have you had, or do you experience…

	YES	NO
Fracture	○	○
Nausea/Vomiting	○	○
Fever/Chills/Sweats	○	○
Unexplained weight change	○	○
Numbness or tingling	○	○
Changes in appetite	○	○
Difficulty swallowing	○	○
Headaches	○	○
Shortness of breath	○	○
Dizziness	○	○
Upper respiratory infection	○	○
Urinary tract infection	○	○



Please **circle** area of pain or discomfort and indicate how long you've experienced the symptoms.

Do you, or have you in the past, smoke tobacco?

○ No ○ Yes, _____ Packs X _____ Years

Last tobacco use? _____

Do you drink alcoholic beverages?

○ No ○ Yes, _____/week

Height: _____ft. _____in.

Weight: _____ lbs.

Date of last physical examination: _____

Name of Physician: _____

Your Name: _____

List medications currently using, the reason for using and dosage:

_____

_____

_____

_____

_____

Surgical History:

Body Region: _____

Surgery Type: _____

When: _____

Body Region: _____

Surgery Type: _____

When: _____