



**sundance**  
physical therapy, inc.

\_\_\_\_\_  
First Name Last Name Social Security or Drivers License #

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date of Birth Age Sex Marital Status 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: In an attempt to reduce paper waste and added administrative costs, we are moving to paperless billing. Please indicate your preference for receiving billing correspondence/statements:  E-mail or  USPS Mail

Appointment Reminders:  via E-mail  via Text: Provide cell phone 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](http://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: \_\_\_\_\_



**MEDICARE PATIENTS**

**Initial**

Have you received any Physical Therapy or Speech Therapy since January 1, 2020?  No  Yes  
 You have an annual limit of \$2080. 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 \$25 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

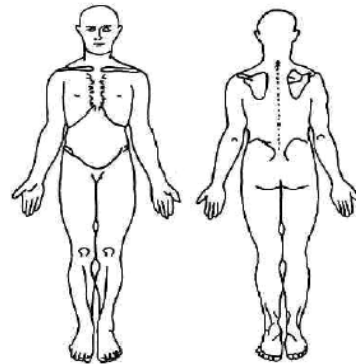


**MEDICAL HISTORY**

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

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

	YES	NO
Fracture	<input type="radio"/>	<input type="radio"/>
Nausea/Vomiting	<input type="radio"/>	<input type="radio"/>
Fever/Chills/Sweats	<input type="radio"/>	<input type="radio"/>
Unexplained weight change	<input type="radio"/>	<input type="radio"/>
Numbness or tingling	<input type="radio"/>	<input type="radio"/>
Changes in appetite	<input type="radio"/>	<input type="radio"/>
Difficulty swallowing	<input type="radio"/>	<input type="radio"/>
Headaches	<input type="radio"/>	<input type="radio"/>
Shortness of breath	<input type="radio"/>	<input type="radio"/>
Dizziness	<input type="radio"/>	<input type="radio"/>
Upper respiratory infection	<input type="radio"/>	<input type="radio"/>
Urinary tract infection	<input type="radio"/>	<input type="radio"/>



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

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

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**Surgical History:**

Body Region: \_\_\_\_\_

Surgery Type: \_\_\_\_\_

When: \_\_\_\_\_

Body Region: \_\_\_\_\_

Surgery Type: \_\_\_\_\_

When: \_\_\_\_\_

**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:** \_\_\_\_\_