

### ***Patient Information***

First Name: \_\_\_\_\_ MI: \_\_\_\_ Last Name: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Gender: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Preferred Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

*May we leave a message?* ☐ No ☐ Yes

*May we leave a message?* ☐ No ☐ Yes

Address: \_\_\_\_\_

Email: \_\_\_\_\_ @ \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Emergency Contact Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Employment: FT PT NA Student Retired Occupation: \_\_\_\_\_

Name of Employer / School: \_\_\_\_\_

Did you have surgery for this issue? ☐ No ☐ Yes Date: \_\_\_\_\_ Date of onset: \_\_\_\_\_

Have you previously had physical therapy for this diagnosis? ☐ No ☐ Yes Details: \_\_\_\_\_

### ***In the past 6 months, have you received or are you currently receiving any of the following:***

Please circle any that apply

**Pulmonary Rehab**

**Speech Therapy**

**Cardiac Rehab**

**Occupational Therapy**

**Home Healthcare**

**Chiropractic Care**

Date of Admission: \_\_\_\_\_

Date of Discharge: \_\_\_\_\_

**Per Insurance, Physical Therapy cannot occur on the same day as appointments for care listed above.**

### ***Workers' Compensation / Motor Vehicle Accident***

Did the injury happen at work? ☐ No ☐ Yes

*If yes, is there a workers compensation claim?* ☐ No ☐ Yes

Is the injury related to an auto accident? ☐ No ☐ Yes

*If yes, in which state did the injury occur?* \_\_\_\_\_

WC or Auto (PIP) Insurance Company: \_\_\_\_\_

Adjuster / Case Manager Name: \_\_\_\_\_ Phone: \_\_\_\_\_

## ***HIPAA Notice & Acknowledgement***

*I acknowledge that I have received / been offered the Notice of Privacy Practices.*

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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### ***Authorization For Use or Disclosure of Information (optional)***

My protected health information may be disclosed to the following:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

*I understand that, as set forth in The Therapy Institute, LLC Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time, by sending written notification to:*

The Therapy Institute, LLC  
1673 Haslett Rd., Suite A  
Haslett, MI 48840  
Attn: Privacy Officer

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*I understand that:*

- A revocation is not effective to the extent that The Therapy Institute, LLC has relied on the use or disclosure of the protected health information.

*I understand that I have the right to:*

- Inspect or copy my protected health information to be used or disclosed as permitted under the federal law (or state law to the extent that the state law provided greater access rights).
- Refuse to sign this authorization.

***With my signature below, I agree to the following:***

- **I authorize The Therapy Institute to provide physical therapy prescribed by my physician and/or considered necessary or advisable by my physician, physical therapist, or other healthcare professional.**
- I authorize the release of information requested by my insurance plan for payment.
- I understand that verification of insurance benefits is done as a courtesy and is not a guarantee of payment, coverage, or benefits stated by my insurance carrier.
- I understand that I am financially responsible for any balance not covered by my insurance carrier.

**Patient / Personal Representative Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Printed Name of Patient / Personal Representative: \_\_\_\_\_

Authority of Representative: \_\_\_\_\_



## Scheduling, No-Show & Cancellation Policy

*We value every patient's time and strive to provide timely access to care for everyone in our community. When appointments are missed without notice, it prevents us from offering those appointment times to another patient who may be waiting to be seen. Your communication helps us maintain an efficient schedule and continue to provide the highest level of care to all our patients. We greatly appreciate your understanding and cooperation.*

We kindly request at least **24 hours'** notice if you need to cancel or reschedule your appointment.

We understand that emergencies and unexpected situations can arise. Patients who are unable to provide 24 hours' notice are encouraged to contact us as soon as possible.

**A no-show fee of \$30** will be charged for appointments that are missed **without any communication or notification** from the patient prior to the scheduled appointment time.

## Billing Information

We at The Therapy Institute strive to make the billing of your medical insurance as easy as possible. As a service to you, the patient, we bill your insurance provider. We attempt to determine via your insurance provider whether physical therapy is a covered benefit under your active policy, in addition to what your financial responsibility is if any. This, however, is not a guarantee of payment on their behalf. ***We strongly recommend that you, the patient, verify your benefits independently.***

To the best of our ability the information gathered is accurate. However, your medical insurance is a contract between you, the patient, and your insurance provider. The Therapy Institute is not a party to that contract, and you, the patient, are ultimately responsible for payment in full of any balance due.

**Payment of all co-pays or co-insurance charges are expected on a weekly basis. Monies due are payable by cash, check, credit card, or valid HSA card.**

\*The Therapy Institute bills according to current Medicare guidelines. Any co-pays, co-insurance, or deductible due will be submitted to any active secondary insurance, where applicable, or billed to the patient if there is no secondary insurance.

***Thank you***

Patient \_\_\_\_\_ Date \_\_\_\_\_



## Patient Medical History/Medications Form

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Past and Current Medical History/Issues: *(check all that apply)*

- |                                                |                                              |                                                |
|------------------------------------------------|----------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Cardiac               | <input type="checkbox"/> Gastrointestinal    | <input type="checkbox"/> Arthritis             |
| <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Depression/Anxiety  | <input type="checkbox"/> Thyroid               |
| <input type="checkbox"/> Respiratory/Breathing | <input type="checkbox"/> Vision              | <input type="checkbox"/> Alcohol/drug abuse    |
| <input type="checkbox"/> Cancer                | <input type="checkbox"/> Hearing Loss        | <input type="checkbox"/> HIV                   |
| <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Smoking             | <input type="checkbox"/> Kidney                |
| <input type="checkbox"/> Seizures              | <input type="checkbox"/> Blood Clots         | <input type="checkbox"/> Liver/Hepatitis       |
| <input type="checkbox"/> Circulatory           | <input type="checkbox"/> Gout                | <input type="checkbox"/> Allergies             |
| <input type="checkbox"/> Stroke/TIA            | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Anemia                |
| <input type="checkbox"/> Osteoporosis          | <input type="checkbox"/> Autoimmune          | <input type="checkbox"/> Other (explain below) |

Additional comments on health history/other health history not listed above that would be relevant to your care:

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Please list all relevant surgeries:

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Is there anything else about yourself, or your medical/social history/status that you'd like your therapist to know?

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Name\_\_\_\_\_

Date\_\_\_\_\_

Medication List:

Please list **all** prescription and non-prescription/over the counter medications.

| Medication | Frequency |
|------------|-----------|
|            |           |
|            |           |
|            |           |
|            |           |
|            |           |
|            |           |
|            |           |
|            |           |
|            |           |

Allergies or reactions (including medications, latex, etc.):

| Medication/Agent | Reaction | Medication/Agent | Reaction |
|------------------|----------|------------------|----------|
|                  |          |                  |          |
|                  |          |                  |          |

# Symptom Location

Please indicate on the body chart below where you are experiencing the symptoms that are bringing you into therapy TODAY. *Previous symptoms and episodes may be reviewed by your therapist during your evaluation.*

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

