FERRELL-WHITED
PHYSICAL THERAPY
SERVICES

PATIENT INFORMATION

Today's Date: _____

Name: _____ SS#: _____/_____/_____

☐Male ☐Female Date of Birth: ____/____/____ Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Address: _____
Street Address City State Zip Code

Email Address: _____ Fax: (_____) _____-_____

Would you like to receive appointment reminders by email? ☐ Yes, Notify me by email. ☐ No, Do not email me.

Home Phone: (_____) _____-_____ ☐Work or ☐Cell Phone: (_____) _____-_____

Would you like to receive appointment reminders via text message? ☐ Yes, Notify me by text. ☐ No, Do not text me.

Drivers License #: _____ State Issued: _____ *Please provide a copy for our records.*

Employer: _____ Occupation: _____
(REQUIRED FOR WORKER COMPENSATION CASES)

Emergency Contact: _____

Ph: (__ ____) _____-_____ Relationship to patient: _____

PHYSICIAN INFORMATION

Referring Physician: _____ Date of Current Injury: _____

Office Address: _____ Ph: (_____) _____-_____
Street Address City State Zip Code

AUTHORIZATION FOR TREATMENT

I hereby consent to and authorize all therapy treatments, which in conjunction with the judgment of my attending physician, may be considered necessary and/or advisable for the diagnosis and/or treatment of the patient named above at Ferrell-Whited Physical Therapy Services.

Signature: _____ Date: _____
(Parent or Legal Guardian must sign if patient is under 18 years of age)

Relationship to Patient: □ Self □ Mother □ Father □ Legal Guardian

ALL INFORMATION ON THIS FORM IS CONFIDENTIAL

FERRELL-WHITED
PHYSICAL THERAPY SERVICES

FERRELL-WHITED PHYSICAL THERAPY FINANCIAL POLICY – 2017

Thank you for choosing Ferrell-Whited Physical Therapy Services (FWPT) as your health care provider. We are committed to building a successful therapist-patient relationship with you and your family. Your clear understanding of our patients' financial responsibility is important to our professional relationship.

INSURANCE: In order to properly bill your insurance company, we require that you disclose **ALL** insurance information including primary and secondary insurance, as well as, any change of insurance information. I understand and agree that insurance claim forms will be submitted to my insurance company as a matter of convenience only, and that I am responsible for all charges regardless of my existing medical coverage. If you are not insured by a plan we participate in you are responsible for out-of-network rates. Your medical claim will be forwarded to your secondary insurance (if any) after payment and/or explanation of benefits (EOB) is received from your primary insurance company

NO-SHOW/CANCELLATION POLICY: We understand there are times when you must miss an appointment due to an emergency. However, I understand that my doctor has prescribed physical therapy for me and this is an on-going process which requires regular attendance. If I am late for an appointment, I may have to reschedule or accept an abbreviated treatment for that day. If I cancel/no-show three appointments, FWPT has the right to discharge me from care. I understand and agree that ***FWPT requires a 24-hour advance notice of cancellation***. **IF I FAIL TO GIVE 24-HOUR NOTICE OF CANCELLATION OR NO-SHOW AN APPOINTMENT, *I WILL BE RESPONSIBLE FOR A $40.00 CHARGE (WHICH IS NOT COVERED BY INSURANCE).***

MEDICARE: We are a participating Medicare provider. **Per Medicare guidelines patients who are receiving in-home health care are not eligible for outpatient physical therapy services at the same time.** I understand it is my responsibility to inform FWPT immediately if in-home health services will be utilized at any time during the course of treatment at FWPT.

COPAYMENTS AND DEDUCTIBLES: All co-pays must be paid at the time of service.

SELF PAY/CASH PAY: For the first appointment there will be a charge of $140.00. For each follow-up appointment there will be an $80.00 charge per visit. PAYMENT IS DUE AT TIME OF SERVICE.

NON-COVERED SERVICES: Please be aware that some of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. **You are responsible for payment of these services.**

WORKERS COMPENSATION: This office is a certified Ohio Bureau of Worker's Compensation provider and accepts approved claims. Any Disallowed Claim fees will be the patient's responsibility.

BILLING SERVICE: Signature Billing Solutions, LLC will be processing all claims and sending statements. Please phone our billing service at **330-952-1554** for any questions concerning your statement balances and payments made on your account. Please let the billing office know if you have any difficulties resolving your bill. In the event that your insurance company should happen to send payment to you, the patient, we expect that you would forward it to our office to be applied to your balance.

FERRELL-WHITED PHYSICAL THERAPY FINANCIAL POLICY – 2017 (continued)

DELINQUENT ACCOUNTS/COLLECTIONS: Account balances over 90 days will be sent to collections after no response from the patient. Statements will be mailed once per month for three months before becoming delinquent. **It is the patient's responsibility to inform the staff of any changes in address or insurance information.**

I agree to be responsible for payment of all services rendered on my behalf or that of my dependents. I acknowledge and accept this Financial Policy.

PRINT Patient Name: _____

Signature of Patient: _____
(Parent or legal guardian must sign if patient is under 18 years of age.)

Relationship to Patient: _____ Date: _____

INSURANCE INFORMATION

Primary (#1) Insurance Company: _____

Principal Policyholder's Name: _____ Date of Birth: _____

Secondary (#2) Insurance Company: _____

Principal Policyholder's Name: _____ Date of Birth: _____

Third (#3) Insurance Company: _____

Principal Policyholder's Name: _____ Date of Birth: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Ferrell Whited Physical Therapy Services reserves the right to modify the privacy practices outlined in the notice.
I have received a copy of the Notice of Privacy Practices for Ferrell Whited Physical Therapy Services.

PRINT Name of Patient: _____

Signature of Patient: _____
(Parent or legal guardian must sign if patient is under 18 years of age.)

Relationship to Patient: _____ Date: _____

OFFICE USE ONLY *Documentation of Attempt to Obtain Acknowledgement of Receipt of Privacy Practices Date:* _____
The acknowledgement was not obtained because the patient declined to sign the acknowledgement. _____
Other Reason: _____
Name of Patient: _____ *Name of FWPT Employee:* _____

Medical History

Existing or Relevant Previous Conditions

Allergies	◯ Yes ◯ No	Dizzy Spells	◯ Yes ◯ No	MRSA	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Emphysema/Bronchitis	◯ Yes ◯ No	Multiple Sclerosis	◯ Yes ◯ No
Anxiety	◯ Yes ◯ No	Fibromyalgia	◯ Yes ◯ No	Muscular Disease	◯ Yes ◯ No
Arthritis	◯ Yes ◯ No	Fractures	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Gallbladder Problems	◯ Yes ◯ No	Parkinsons	◯ Yes ◯ No
Autoimmune Disorder	◯ Yes ◯ No	Headaches	◯ Yes ◯ No	Rheumatoid Arthritis	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Hearing Impairment	◯ Yes ◯ No	Seizures	◯ Yes ◯ No
Cardiac Conditions	◯ Yes ◯ No	Hepatitis	◯ Yes ◯ No	Smoking	◯ Yes ◯ No
Cardiac Pacemaker	◯ Yes ◯ No	High/Low blood pressure	◯ Yes ◯ No	Speech Problems	◯ Yes ◯ No
Chemical Dependency	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Strokes	◯ Yes ◯ No
Circulation Problems	◯ Yes ◯ No	HIV/AIDS	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Currently Pregnant	◯ Yes ◯ No	Incontinence	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Depression	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Vision Problems	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Metal Implants	◯ Yes ◯ No		

Surgical History

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

Current Medications

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

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Additional Information:

_____

_____

_____

_____

_____

_____

_____

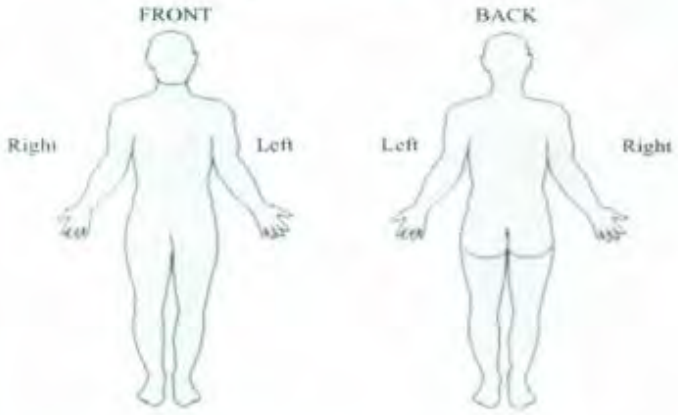
_____

_____

Injury as a result of a fall in the past year? _____
Two or more falls in the last year? _____

Pain Diagram

- Shade in affected area(s).
- Label type of sensation or pain in each area
  Example: Burning, aching, throbbing, stabbing, tingling, numbness, etc.



Draw a line on the pain intensity scale at the point that best describes your pain at the PRESENT time:

_____

0(No Pain) 1 2 3(Mild) 4 5(Moderate) 6 7(Severe) 8 9(Excruciating) 10 (Pain as bad as it could be)

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Signature of Patient: _____

(Parent or legal guardian must sign if patient is under 18 years of age.)

Relationship to Patient: _____ Date: _____

OFFICE USE ONLY

Documentation of Attempt to Obtain Acknowledgement of Receipt of Privacy Practices
An attempt was made to obtain an acknowledgement of receipt of privacy practices. The acknowledgement was not obtained because:
The patient declined to sign the acknowledgement. _____ *Other Reason:* _____
Name of Patient: _____
Name of FWPT Employee: _____ *Date:* _____