



## Stewart Physical Therapy Clinic, Inc.

### **PATIENT INFORMATION**

Welcome to Stewart Physical Therapy Clinic, Inc. We are excited for the opportunity to assist you with your rehabilitation needs. The Physical Therapist / Occupational Therapist will work closely with your doctor and/or rehabilitation specialist to develop a treatment plan specifically designed for you. The following are a few items designed to make your treatment sessions as cost and time effective as possible as well as maximizing your rehabilitation goals.

#### **ATTENDANCE POLICY**

All patients are encouraged to arrive on time for their appointment. Your active participation is required to receive the maximum benefit from your rehabilitation program. If you find that you cannot keep your appointment, please call to reschedule as soon as possible so we may fill your appointment time with another patient. If you are a Workman's Compensation patient, we are required to notify your employer, case manager and your physician of any missed or cancelled appointments. Compliance with your physician's rehabilitation prescription is important. Frequent cancellations or no shows by any patient will be reported to the referring physician.

#### **PROPER DRESS**

Please wear or bring proper attire for your treatment. Comfortable shoes and loose fitting clothing are recommended. For knee injuries, shorts are preferred.

#### **SUPPLIES**

Some supplies such as theraband, elastic tubing, arm pulleys, and braces may be giving to you from your therapist to assist in your recovery at home. Your insurance company may not cover these items and you will be responsible for payment at the time they are issued to you.

We are looking forward to working with you to achieve your rehabilitation goals and to return you to your normal lifestyle as quickly as possible. Thank you.

\_\_\_\_\_  
Patient Signature

Date \_\_\_\_\_

\_\_\_\_\_  
Therapist Signature

Date \_\_\_\_\_



**Stewart Physical Therapy Clinic, Inc.**  
**PATIENT REGISTRATION**

Chart #: \_\_\_\_\_ Referring Doctor: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Full Name: \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_ Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_

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

Work Phone #: \_\_\_\_\_ Employer: \_\_\_\_\_

Marital Status: M D W S Spouse Name: \_\_\_\_\_ Spouse Employer: \_\_\_\_\_

Name, Relationship, & Phone # for Emergency Contact: \_\_\_\_\_

Onset Date/Accident Date: \_\_\_\_\_ Nature of Injury/Illness: \_\_\_\_\_

Surgery Date: \_\_\_\_\_ Are you receiving any home health care? \_\_\_\_\_ Yes \_\_\_\_\_ No

Whom may we thank for your referral? \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

**INSURANCE**

WE MUST HAVE A COPY OF ALL INSURANCE CARDS, FRONT AND BACK, WE WILL VERIFY COVERAGES AND INFORM YOU OF ANY LIMITATIONS PRIOR TO CLAIMS PROCESSING.

Your Insurance Company: \_\_\_\_\_

Other Insurance Info/Spouse Insurance

Spouse Name: \_\_\_\_\_ Employer: \_\_\_\_\_

Insurance Co: \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_

Work Phone #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Was this an auto accident? \_\_\_\_\_ Yes \_\_\_\_\_ No Are you represented by an attorney? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, list name and phone #: \_\_\_\_\_

Was this an injury at work? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, was it reported to your employer? \_\_\_\_\_ Yes \_\_\_\_\_ No

**AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS**

I authorize Stewart Physical Therapy to release medical information necessary to process insurance claim(s) on my behalf for services rendered. I request payment of any medical insurance, auto insurance, or liability proceeds or settlements to be made directly to Stewart Physical Therapy. I understand that I am responsible for any balance remaining after insurance or settlement from all sources. I agree to pay any remaining balance within 30 days. If I fail to pay any remaining balance due, Stewart Physical Therapy will have the right, to the extent allowed by law, to be paid back by me for all costs and expenses incurred in collecting sums due and in enforcing my agreement to pay, including but not limited to, reasonable attorneys fees.

Guarantor/

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



Stewart Physical Therapy Clinic, Inc.  
**MEDICAL INFORMATION**

Chart Number: \_\_\_\_\_ Referring Doctor: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Next Doctor's Appt: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Date of Surgery: \_\_\_\_\_

Are you allergic to any medications? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please list \_\_\_\_\_

Are you diabetic? \_\_\_\_\_ Yes \_\_\_\_\_ No Do you take insulin? \_\_\_\_\_ Yes \_\_\_\_\_ No

Have you ever had surgery? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please list \_\_\_\_\_

Do you suffer from dizziness, fainting, seizures, or convulsions? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please explain \_\_\_\_\_

Do you have high blood pressure? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please explain \_\_\_\_\_

Do you have a heart condition? \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you have a pacemaker? \_\_\_\_\_ Yes \_\_\_\_\_ No

Have you ever had a blood clot or phlebitis? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please explain \_\_\_\_\_

Are you currently or have you in the past, received treatment for cancer? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, when \_\_\_\_\_

Do you have any other health problems? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please describe \_\_\_\_\_

Please list any prescription medication you are currently taking \_\_\_\_\_

\_\_\_\_\_

FEMALES ONLY: Are you or could you be pregnant? \_\_\_\_\_ Yes \_\_\_\_\_ No

Patient or Legal Guardian Signature \_\_\_\_\_



## **Stewart Physical Therapy**

### **NO SHOW POLICY**

A \$25.00 NO SHOW FEE WILL BE CHARGED TO ALL PATIENTS WHO DO NOT CALL TO GIVE ADEQUATE NOTICE OF CANCELLATIONS. THIS FEE WILL NOT BE BILLED TO THE INSURANCE COMPANY AND MUST BE PAID BY THE PATIENT.

EXCEPTIONS WILL BE MADE FOR UNEXPECTED ILLNESSES OR OTHER EXTENUATING CIRCUMSTANCES DEEMED APPROPRIATE BY THE PHYSICAL THERAPISTS.

PATIENT NAME: \_\_\_\_\_

DATE: \_\_\_\_\_



## Stewart Physical Therapy Clinic, Inc.

### Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Stewart Physical Therapy Clinic's, Inc. may use and disclose protected health information about me to carry out treatment, payment, and healthcare operations. Please refer to Stewart Physical Therapy Clinic's, Inc. Notice of Privacy Practices for more complete description of such disclosures.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Stewart Physical Therapy Clinic's, Inc. may decline to provide treatment to me.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Stewart Physical Therapy Clinic's, Inc. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Stewart Physical Therapy Clinic's, Inc.

With my consent, Stewart Physical Therapy Clinic's, Inc. may call my home or other designated locations and leave a message on my voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance items and any call pertaining to my care.

With my consent, Stewart Physical Therapy Clinic's, Inc. may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment and healthcare operations, such as patient statements as long as they are marked Personal and Confidential.

With my consent, Stewart Physical Therapy Clinic's, Inc. may email to my home or other designated location any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders and patient statements. I have the right to request Stewart Physical Therapy Clinic's, Inc. restrict how it uses or discloses my protected health information to carry out treatment, payment and healthcare operations. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Stewart Physical Therapy Clinic's, Inc. use and disclose of my protected health information to carry out treatment, payment and healthcare operations.

I understand that Stewart Physical Therapy Clinic's, Inc. will file my insurance and that I will be responsible for any copay, deductibles, coinsurance, or non-covered services. I assign payment directly to Stewart Physical Therapy Clinic's, Inc. for the purpose of satisfying my account, but payment is not to exceed the regular charges. It is further agreed that any credit balance resulting from payment of the insurance or other sources may be applied to any other account owed to the practice by the insurance of his/her family. If I have questions or decide otherwise I will contact Stewart Physical Therapy Clinic's, Inc.

Patient or Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_