



## New Patient Information

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Date: \_\_\_\_\_ Marital Status:    Married    Single    Divorced    Widowed

Patient Name: \_\_\_\_\_ Name of Spouse/Parent: \_\_\_\_\_

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

Zip Code: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Phone #:(    )\_\_\_\_\_ Age:\_\_\_\_\_ Sex: \_\_\_\_ Driver's License#:\_\_\_\_\_

Party Responsible for Payment: \_\_\_\_\_ DOB:\_\_\_\_\_

Relationship:    Self    Spouse    Natural Child    Step Child    Foster Child    Other \_\_\_\_\_

Address of Party Responsible for Payment: \_\_\_\_\_

Zip Code: \_\_\_\_\_ Drivers license#:\_\_\_\_\_ Phone #: (    )\_\_\_\_\_

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

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

Zip code: \_\_\_\_\_ Phone #: (    )\_\_\_\_\_

Referring Physician: \_\_\_\_\_ Next Physician Appointment \_\_\_\_\_

*\*We bill \$25 for a no-show (when you do not notify us you will not be in for an appointment.)*

*Please initial: \_\_\_\_\_*

## Insurance Information

Primary Insurance: \_\_\_\_\_ Phone #: (    ) \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_

ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Secondary insurance: \_\_\_\_\_ Phone #: \_\_\_\_\_

ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Is Injury Employment Related?    Yes    No    Claim#: \_\_\_\_\_

Is Injury Auto Related?    Yes    No    Date of Injury: \_\_\_\_\_

Attorney: \_\_\_\_\_ Phone: (    ) \_\_\_\_\_

121 Cranberry Road • Grove City, PA 16127 • 724-458-WISE  
215 Grove City Road • Slippery Rock, PA 16057 • 724-406-0506



## **PF-2000 Consent to Use and Disclosure of Protected Health Information**

### Use and Disclosure of Your Protected Health Information

Your protected health information will be used by Wise Physical Therapy and Sports Medicine or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

### Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

### Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your protected health information.

Wise Physical Therapy and Sports Medicine may or may not agree to restrict the use or disclosure of your protected health information.

If Wise Physical Therapy and Sports Medicine agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

### Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

### Reservation of Right to Change Privacy Practices

Wise Physical Therapy and Sports Medicine reserves the right to modify the privacy practices outlined in the notice.

### Signature

I have reviewed this consent form and give my permission to Wise Physical Therapy and Sports Medicine to use and disclosure my health information in accordance with it.

\_\_\_\_\_  
Name of Patient (Print or Type)

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient Representative

\_\_\_\_\_  
Relationship of Patient Representative to Patient

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### **1. CONSENT FOR TREATMENT**

I understand that I have been referred to Wise Physical Therapy and Sports Medicine by my physician for physical therapy services. I will be subject to various therapeutic procedures and modalities, such as moist heat, cold packs, ultrasound, electrical stimulation, traction exercise, mobilizations, and other organized procedures utilized by physical therapists. I hereby authorize Wise Physical Therapy and Sports Medicine to treat me as prescribed. If the patient is under the age of 18, a parent or guardian must sign this consent form.

\_\_\_\_\_  
Patient Signature or  
Parent/Guardian

\_\_\_\_\_  
Date

### **2. CONSENT FOR RELEASE OF INFORMATION**

I hereby consent to the release of information concerning my physical condition to third party payers involved in processing claims for payment of treatments administered by Wise Physical Therapy and Sports Medicine. I consent to the use of chart information for research purposes.

\_\_\_\_\_  
Patient Signature or  
Parent/Guardian

\_\_\_\_\_  
Date

### **3. CONSENT FOR PAYMENT AND ASSIGNMENT OF BENEFITS**

I understand that I am financially responsible to Wise Physical Therapy and Sports Medicine for any debts not covered by third party payers which are incurred during the period of time in which I am receiving treatment as prescribed by my physician. I agree to forward to Wise Physical Therapy and Sports Medicine any payments received at my residence for services administered during the period I am receiving treatment. I hereby assign my/our right to receive payment for services rendered for physical therapy, Wise Physical Therapy and Sports Medicine.

\_\_\_\_\_  
Patient Signature or  
Parent/Guardian

\_\_\_\_\_  
Date

### **4. MEDICARE ASSIGNMENT OF BENEFIT AND RELEASE OF INFORMATION**

I hereby request that payment of authorized Medicare benefits be made on behalf of Wise Physical Therapy and Sports Medicine for any services incurred by me. I authorize the holder of medical information about me to release any information needed by the Health Care financing Administration and its agents in order to determine benefits payable in my behalf.

\_\_\_\_\_  
Patient Signature or  
Parent/Guardian

\_\_\_\_\_  
Date

**Medical Record —  
Supplemental Medical Data**



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

**Circle YES or NO...**

**Have you or any immediate family member ever been told you have:**

	<u>Self</u>		<u>Family</u>	
Cancer?	Yes	No	Yes	No
Diabetes?	Yes	No	Yes	No
High blood pressure?	Yes	No	Yes	No
Heart disease?	Yes	No	Yes	No
Angina/chest pain?	Yes	No	Yes	No
Stroke?	Yes	No	Yes	No
Osteoporosis?	Yes	No	Yes	No
Osteoarthritis?	Yes	No	Yes	No
Rheumatoid arthritis?	Yes	No	Yes	No

**In the past 3 months have you had or do you experience:**

A change in <u>your</u> health?	Yes	No
Nausea/Vomiting?	Yes	No
Fever/chills/sweats?	Yes	No
Unexplained weight change?	Yes	No
Numbness or tingling?	Yes	No
Changes in appetite?	Yes	No
Difficulty swallowing?	Yes	No
Changes in bowel or bladder?	Yes	No
Shortness of breath?	Yes	No
Dizziness?	Yes	No
Upper respiratory infection?	Yes	No
Urinary tract infection?	Yes	No
Change in your balance (increased falls)	Yes	No

**Do you or have you in the past smoked tobacco?**

Yes No  
If yes, \_\_\_\_\_ packs X \_\_\_\_\_ Years.  
Last tobacco use: \_\_\_\_\_

**Do you drink alcoholic beverages?** Yes No

If yes, how many drinks do you routinely have per week? \_\_\_\_\_ / Week

**Date of last physical examination**  
\_\_\_\_\_

**Circle YES or NO...**

**Do you have a history of:**

Allergies/Asthma?	Yes	No
Headaches?	Yes	No
Bronchitis?	Yes	No
Kidney disease?	Yes	No
Rheumatic fever?	Yes	No
Ulcers?	Yes	No
Sexually transmitted disease?	Yes	No
Seizures?	Yes	No

**Are you currently:**

Pregnant?	Yes	No
Depressed?	Yes	No
Under Stress?	Yes	No

**Are you symptoms: (check one)**

Getting worse  The same  Improving

**How are you able to sleep at night? (check one)**

Fine  Moderate difficulty  Only with medication

**Do you have a problem with... (check all that apply)**

Hearing  Speech  Vision Communication

**My symptoms are worse in the:**

Morning  Afternoon Evening  Night

**My symptoms are best in the:**

Morning  Afternoon Evening  Night

**List medications currently using:**

\_\_\_\_\_  
\_\_\_\_\_

**Patient's Signature:** \_\_\_\_\_