

# **WELLS PHYSICAL THERAPY SERVICES PATIENT INFORMATION**

175 Wilson Rd. Suite 101 Middlebury, VT 05753 802-388-3533

Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Last First M.I.

Marital Status: (please circle) Married Single Divorced Widowed Other

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ M \_\_\_\_\_ F

Address: \_\_\_\_\_ Town: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home phone: ( ) \_\_\_\_\_ Cell phone: ( ) \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

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

Person to notify in case of emergency: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Family Physician: \_\_\_\_\_

Whom may we thank for referring you to this office? \_\_\_\_\_

**Insurance Information:** Name of Insurance(s): \_\_\_\_\_

Primary Card Holder Name: \_\_\_\_\_

Primary Card Holder Date of Birth: \_\_\_\_\_

Were you injured at work? Yes \_\_\_\_\_ No \_\_\_\_\_ Was this an auto accident? Yes \_\_\_\_\_ No \_\_\_\_\_

Date of accident, if applicable: \_\_\_\_\_

## **Consent for Physical Therapy Treatment**

The medical history information I have provided for the physical therapist is true and complete to the best of my knowledge. I understand it is my responsibility to keep the treating physical therapist updated on my medical condition and history. I agree and give my consent for Wells Physical Therapy Services to provide physical therapy evaluation, care and treatment considered necessary and proper in diagnosing and /or treating my physical condition.

**Signature of Patient/Legal Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_







**PATIENT HEALTH INFORMATION**

(This questionnaire is considered a part of your confidential medical records)

Patient Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

1. What is your present injury or issue?: \_\_\_\_\_
2. Is it on your \_\_\_Right Side \_\_\_Left Side \_\_\_Both Sides \_\_\_Not Applicable
3. How did your injury or issue occur?: \_\_\_\_\_
4. Where were you when it occurred?: \_\_\_\_\_
4. Have you undergone diagnostic tests for this current condition? \_\_\_Yes \_\_\_No  
(If yes, what and where can the report be located? \_\_\_\_\_)

5. Please rate your pain: 0 being 'No Pain' and 10 being 'hospitalization'.

- |   |                                  |  |              |
|---|----------------------------------|--|--------------|
|  | 0__1__2__3__4__5__6__7__8__9__10 |  | At its Worst |
|  | 0__1__2__3__4__5__6__7__8__9__10 |  | Currently    |
|  | 0__1__2__3__4__5__6__7__8__9__10 |  | At its Best  |

**MEDICAL HISTORY:** (Please check if **you** have a history of)

- |  |                                |                          |
|--|--------------------------------|--------------------------|
| _____ High Blood pressure                          | _____ Heart Disease            | _____ Chest pain/Angina  |
| _____ Asthma/Lung disease                          | _____ Shortness of breath      | _____ Thyroid Condition  |
| _____ Arthritis                                    | _____ Diabetes                 | _____ Low blood sugar    |
| _____ Headaches                                    | _____ Cancer                   | _____ Osteoporosis       |
| _____ Smoker _____ packs per _____                 | _____ Fractures (Broken bones) | _____ Impaired vision    |
| _____ Unusual joint pain/swelling                  | _____ Impaired hearing         | _____ Epilepsy           |
| _____ HIV / AIDS                                   | _____ Hepatitis                | _____ Currently pregnant |
| _____ Pacemaker or electronically sensitive device |                                | _____ Other              |

6. Do you have any problems with your bowels or bladder? \_\_\_No \_\_\_Yes

7. Do you have an allergy to latex? \_\_\_Yes \_\_\_No Other Allergies: \_\_\_\_\_  
\_\_\_\_\_

8. Have you had any previous surgeries? If yes, what: \_\_\_\_\_  
\_\_\_\_\_

9. In choosing physical therapy services, what do you hope to achieve? \_\_\_\_\_  
\_\_\_\_\_

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

## MEDICATIONS LIST

*Please include all Prescription, over-the-counter, herbal and vitamin/mineral dietary supplements.*

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

<b>Medication Name</b>	<b>Dosage</b>	<b>Frequency</b>	<b>Route</b> i.e.—Oral, Injection

*I attest that the documented current medication information is accurate and complete to the best of my knowledge and ability at the time of this appointment.*

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

*Patient Authorization to Use or Disclose Protected Health Information*

I, \_\_\_\_\_, authorize Wells Physical Therapy Services or its Business Associates to use or disclose my protected health information as described below to the recipients indicated.

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*(physician name)*

*Other recipients or information? (Specify):* \_\_\_\_\_

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*I authorize Wells Physical Therapy Services to call me or leave messages at the following number(s) \_\_\_\_\_.*

I, \_\_\_\_\_, understand that Wells Physical Therapy Services creates and maintains health records describing my medical history, diagnoses, evaluation results, treatment, and plans for future treatment. This information may serve as: a basis for planning my care and treatment, a means of communication among health professionals who contribute to my care, a source of information for applying my diagnosis and treatment information to my bill, a means by which a third-party payer can verify services billed were provided, and a tool for routine healthcare operations such as assessing quality.

A ***Notice of information Practices*** that more completely describes how your medical information may be used or disclosed is displayed throughout the clinic and copies are available to you upon request. You have the right to review this notice prior to signing this consent. Wells Physical Therapy Services reserves the right to change its notice and practices. If this occurs during the course of your treatment here, a revised statement will be brought to your attention.

You have the right to request restrictions as to how your health information may be used or disclosed to carry out treatment, payment, or healthcare operations. You may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

When information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may then no longer be protected health information. You have the right to inspect or copy the information to be used or disclosed and may refuse to sign this authorization. You have a right to revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization. In order for the revocation to be effective, Wells Physical Therapy Services must receive a signed, dated revocation in writing.

*I have read and fully understand and accept the terms of this authorization. I acknowledge that I have been offered a full copy of the Wells Physical Therapy HIPAA policy for Use or Disclosure of Protected Health Information*

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*Signature of Patient or Legal Guardian*

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*Date*

# Wells Physical Therapy Billing & Payment Agreement

Ultimately you are responsible for:

- \* Knowing your insurance coverage terms & benefits for treatment in our clinic.
- \* Providing accurate and up to date insurance coverage information to Wells PT for the purpose of billing your visits.
- \* **You are directly responsible for payment of services you receive from Wells Physical Therapy Services.** This may include copays, deductibles & coinsurances as well as non-covered services. Other items **not often** covered by insurance can include equipment **vital to our therapy, both for your home and in-clinic program.** This could include *theraband, balls, electrodes, kinesiotape and heel lifts*. You and your therapist will discuss the medical necessity of these items at the time of your visit.
- \* You are responsible for obtaining any referrals or scripts required by your insurance company in order to pay for your services here at Wells.

We require payment of copays, equipment and non-covered services at the time of your visit

## We Bill Your Insurance First:

As a courtesy to you, our billing department will submit your visit fees rendered at this office to your health insurance company in a timely manner. Please be advised that your insurance policy is a **contract between you and your insurance company.** Any verification of benefits we do on your behalf is not final until the insurance company has received the claim and adjudicated. If you ever have any questions regarding your coverage, please contact your insurance company directly.

*I have read and understand the preceding information and agree to meet my obligations for payment of the services I have accepted at Wells Physical Therapy*

## Statements & Payment Plans:

For those services not collected at the time of your visit, Wells Physical Therapy will send you a monthly statement. Payment of your statement balance is due at the time of receipt unless a payment plan agreement has been signed with the billing manager.

## We Accept:

- \*Cash & Personal Check
- \*Debit Cards
- \*Visa, Mastercard, Discover, Amex
- \*Credit Cards
- \*HSA Cards
- \*Wells AutoPay Program

**Billing Manager Lisa Perkins is your partner regarding finances here at Wells. Call 802-388-3533 for any questions or issues regarding your statement, billing or finances**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date