Agape
Physical Therapy & Sports Rehabilitation

Patient Name: _____ DOB: _____

CONSENT TO TREATMENT

I consent to rehabilitation and related services at Agape PT and Sports Rehab. In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touch and /or direct contact of a sensitive nature. _____

TREATMENT OF MINORS

I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during such treatment, and waive any claim I may have resulting from failure to do so. _____

LIABILITY

I know and agree that Agape PT and Sports Rehab is not responsible for loss or damage to personal valuables. _____

WAIVER AND RELEASE

I hereby release, discharge and acquit: Agape PT and Sports Rehab, its agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services. _____

AUTHORIZATION OF PAYMENT

I hereby assign all benefits directly to: Agape PT and Sports Rehab. I also authorize release of any medical records to other healthcare providers as necessary to facilitate my treatment and to other third parties as necessary to process medical claims and otherwise permitted or required in the Notice of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment. _____

NOTICE OF PRIVACY/PATIENT BILL OF RIGHTS

I acknowledge receipt of Notice of Privacy Practices. _____

I acknowledge receipt of the Statement of Patient Rights. _____

DISCLOSURE OF MEDICAL RECORDS

I authorize the following individuals to have access to my medical and billing records:

_____ _____
Name Relationship

_____ _____
Name Relationship

I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature _____ Date _____

Witness Signature _____ Date _____

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NEW PATIENT INFORMATION/MEDICAL HISTORY FORM

(Please print neatly)

Patient Name: _____ Age: _____ DOB_____

Sex: ☐ M ☐ F Height: _____ Weight_____ ☐ Right Hand dominant ☐ Left hand dominant

Current Medications-Include Prescription and Over the Counter (include doses/frequency, if known)

List additional on back of page if necessary. If you have a list of your medications, we will gladly make a copy.

_____

_____

_____

Allergies: _____

Emergency Contact(s): _____Rel_____

Ph: _____ Alt Ph: _____

Social History: # of people in household_____ Approx. # of steps in house___ Are you able to drive? ☐YES ☐NO

Medical History:

Please mark with an "X" if you have symptoms of, are currently receiving treatment, or have been treated for, any of the following:					
	Stroke		Diabetes		Swelling in the arms or legs
	Heart Attack		Seizures		Allergic reaction to bee stings
	High Blood Pressure		Dizziness		Balance problems
	Chronic Respiratory Disease		Visual problems		Orthopedic disease
	Cardiovascular Disease		Other:		
	Cancer: Type- *When?* *Are you currently being treated?*				

What is your primary reason for coming to Physical Therapy? (Chief Complaint)

_____

Date of your injury/date symptoms began: _____ _____

Is this injury resulting from: Work injury? __NO __YES Auto accident?__NO __YES (list date on line above)

Have you been treated for this problem before? ___NO ___YES When? _____

When did you last see the doctor who referred you to physical therapy? _____

Are you scheduled to return to the doctor for a follow-up visit ___NO ___YES When? _____

For your current injury, list any diagnostic tests, results, and date completed *(MRI, X-Ray, EMG, CAT Scan, etc)*

_____

_____

Please indicate the level of pain or symptoms that you experience when performing the following activities:
Use 1 to 10 scale, 0= No pain whatsoever 10=Worst imaginable pain

_____Dressing ____Sleeping ____Toileting ____ Hobbies ____Driving ____Stairs ____Bathing
_____House Chores ____Meal Preparations ____Exercise/Sports ____Other: _____

Are you currently working outside the home? ___NO __YES Occupation/type of work_____

Name of Employer: _____ City/state: _____

Functions_____

Limitations/Restrictions_____

_____

Patient/Guardian Signature: _____ **Date**_____

Therapist Signature: _____ **Date** _____

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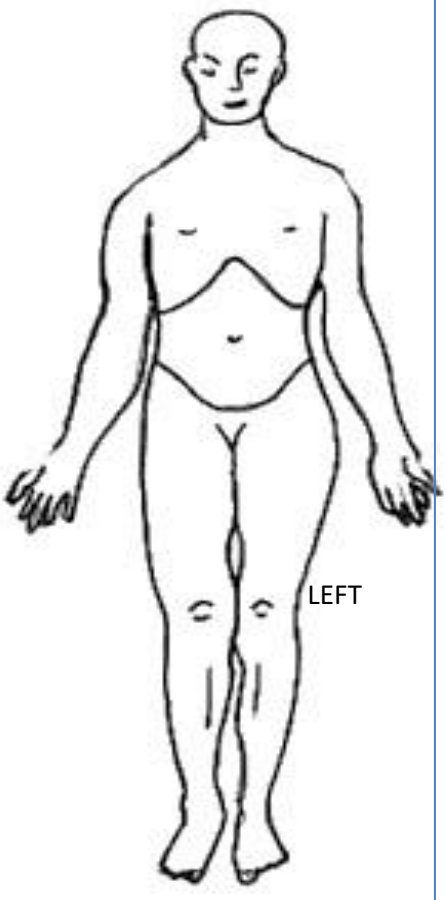
Patient Name_____ Date of Birth_____

PAIN CHART

PLEASE MARK WITH AN "X" ALL AREAS THAT YOU HAVE **CONSTANT** PAIN

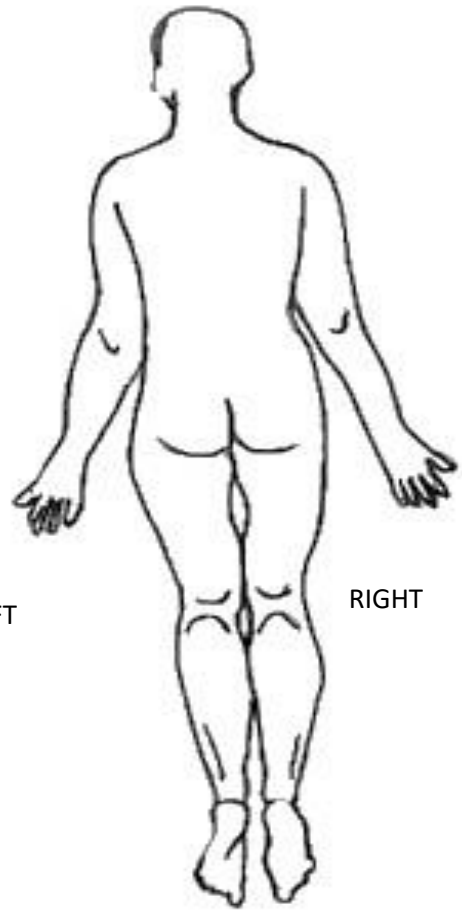
PLEASE MARK WITH AN **"O"** ALL AREAS THAT YOU HAVE **INTERMITTENT** PAIN

FRONT



RIGHT LEFT

BACK



LEFT RIGHT

CIRCLE YOUR CURRENT PAIN LEVEL

0 1 2 3 4 5 6 7 8 9 10

Use 1 to 10 scale, 0= No pain whatsoever 10=Worst imaginable pain

PATIENT SIGNATURE: _____ DATE: _____

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MEDICARE AUTHORIZATION

I understand that Medicare Part B. will be billed for my services at Agape Physical Therapy and Sports Rehabilitation. I also understand that Medicare will pay 80% of the allowed amount, after the annual deductible amount has been met. I will be responsible for the deductible (if not already met), coinsurance amounts and non-covered charges. I will not be responsible for the non-allowed charges.

I also understand that if I sign up for a Medicare Advantage Plan during my treatment, services may not be covered. Any changes in Medicare enrollment or other Insurance plans during my treatment should be immediately disclosed to the provider.

REQUIREMENTS

Medicare requires that all patients are under the care of their physician. Your physician must authorize your care in order for it to be covered under the Medicare physical therapy benefits.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Agape Physical Therapy and Sports Rehabilitation to apply for benefits for services furnished to me by that provider of care, apply for, and receive payment directly from Medicare. I authorize the release of protected health information about me to the Health Care Finance Administration and its agents as needed to determine these benefits.

MEDICARE SECONDARY PAYER QUESTIONAIRE

All questions must be answered completely pursuant to Medicare requirements.

	YES	NO
1. Are you a Veteran:	_____	_____
A. Did the VA refer you here?	_____	_____
B. Do you have a VA fee basis card?	_____	_____
2. Do you have a Federal Black Lung card?	_____	_____
3. Is this medical condition due to an accident of any kind?	_____	_____

If yes, was it: (circle one)
Work related Automobile related Injury at home Other_____

4. Are you covered by an employer's health insurance plan through your own employment, or of that of a family member, other than Medicare? _____ _____
If yes, please indicate: _____

Patient Name_____
Please print clearly

Signature of Patient or Guardian_____(seal) Date: _____

Witness: _____ Date: _____