



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 _____ **Witness Signature** _____



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. Therapist initials _____

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:

<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Swelling in the arms or legs
<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	Allergic reaction to bee stings
<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	Balance problems
<input type="checkbox"/>	Chronic Respiratory Disease	<input type="checkbox"/>	Visual problems	<input type="checkbox"/>	Orthopedic disease
<input type="checkbox"/>	Cardiovascular Disease	<input type="checkbox"/>	Other:		
<input type="checkbox"/>	Cancer: Type- When?	<input type="checkbox"/>	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 Reviewed /Initial: _____ **Date** _____

Agape

Physical Therapy & Sports Rehabilitation

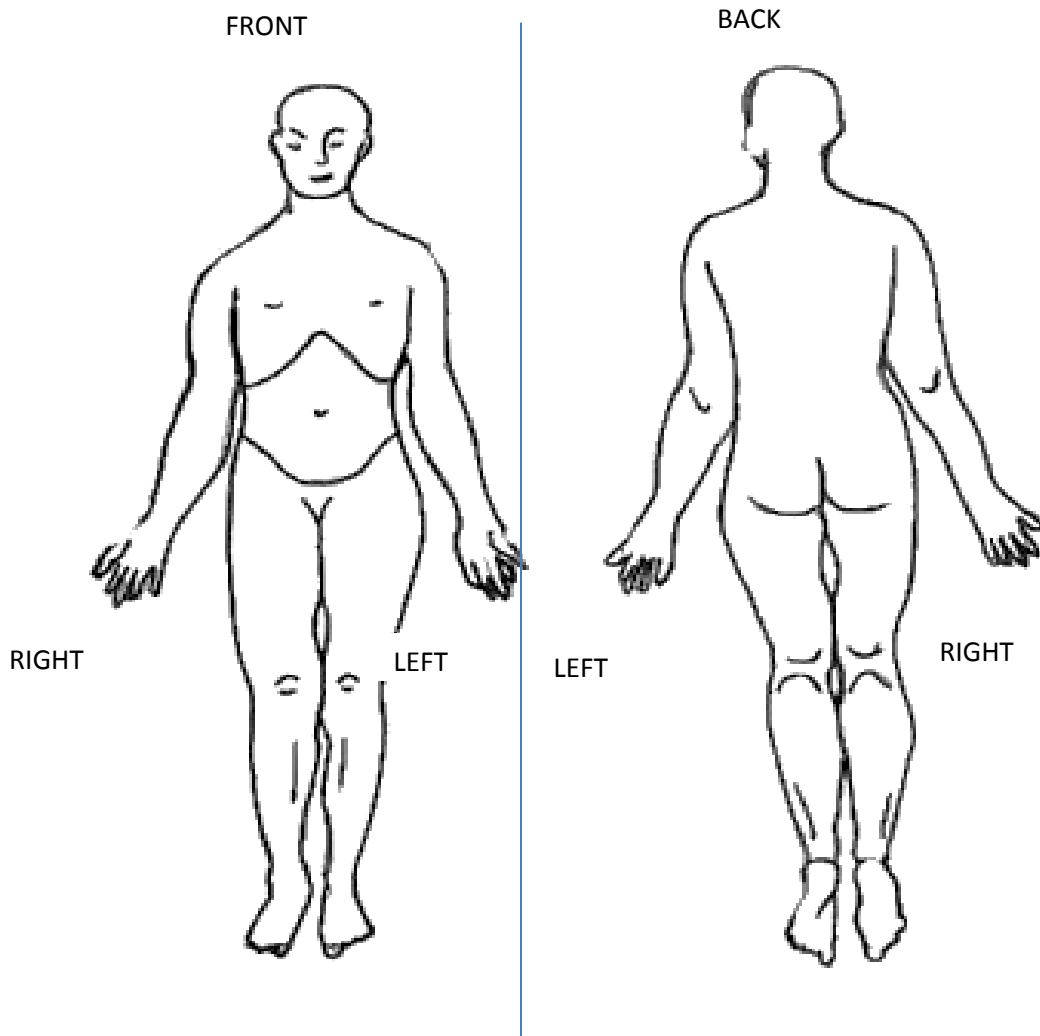
Patient Name _____

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



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: _____

REVIEWED BY THERAPIST: _____ **DATE AND INITIAL**



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 QUESTIONNAIRE

All questions must be answered completely pursuant to Medicare requirements.

- 1. Are you a Veteran: YES NO
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: _____