MARKETPLACE
PHYSICAL THERAPY
& WELLNESS CENTER

CONFIDENTIAL PATIENT HISTORY

**Please complete this questionnaire. This confidential history will be part of your permanent records.*

Full Name:_____**Date of Birth:**___ /___ /____ **Sex: ❑M ❑F**

Address:_____**City**_____ **State**____ **Zip**_____

Home Phone:_____ **Cell Phone:**_____ **Opt in for Text?** ❑ Yes ❑ No

Work Phone:_____ **Best time to reach you:** ❑ Morning ❑ Afternoon ❑ Evening

Soc. Sec. # (Optional):_____ **Occupation:**_____

Emergency Contact Name:_____ **Phone #**:_____

Relation to patient:_____

Is this a Work Comp case? ❑Yes ❑ No Date of injury:_____

If yes, please provide Adjuster Name:_____ **Phone # :**_____

List ALL surgical operations and years:_____

_____

Do you have a primary doctor? ❑Yes ❑No If Yes, Name:_____

Medications, dosage and frequency:_____

_____

Have you previously had physical therapy? ❑Yes ❑No

****Please provide your email address in order to have direct communication with your Physical Therapist and video access to your at Home Care Plan.***

Email Address:_____

How did you hear about us? ❑ Medical Doctor ❑ Google ❑ Yelp ❑ Friend/Family ❑ Returning patient
❑ Other:_____

Privacy Policy Statement

MarketplacePhysical Therapy conforms to all HIPAA (Health Insurance Portability and Accountability Act) privacy regulations. Patients' information will only be used for authorization of treatment and reimbursement for services provided.

Signature of Patient/Parent or Legal Guardian _____***Date:***___***/***___***/***_____

PATIENT HISTORY

Is the treating body part Post Op? No ❑ Yes ❑
Date of Surgery:__/__/___
What is your Major complaint?_____
_____

PLEASE CIRCLE: 1 being no pain 10 being severe pain

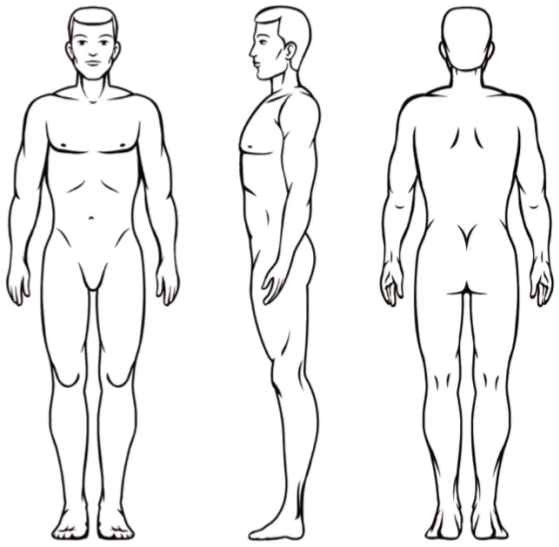
Pain level at worst: 1 2 3 4 5 6 7 8 9 10

Pain level currently: 1 2 3 4 5 6 7 8 9 10

Pain level at best: 1 2 3 4 5 6 7 8 9 10

_____

Weight:_____ Height:_____



MARK THE AREAS OF YOUR SYMPTOMS ON THE FIGURES ABOVE

MARK ALL THAT APPLY BELOW

Stroke	❑Yes ❑ No
Cancer	❑Yes ❑ No
Kidney Problems	❑Yes ❑ No
High Blood Pressure	❑Yes ❑ No
Liver Problems	❑Yes ❑ No
Pacemaker	❑Yes ❑ No
Metal Implants	❑Yes ❑ No
Cardiac Condition	❑Yes ❑ No
Nervous Disorders	❑Yes ❑ No
Are you Pregnant?	❑Yes ❑ No
Unexplained Coughing	❑Yes ❑ No
Heart Attack	❑Yes ❑ No
Respiratory Illness	❑Yes ❑ No
Circulation Problems	❑Yes ❑ No
Arthritis	❑Yes ❑ No
Seizures	❑Yes ❑ No
Reaction on skin to heat	❑Yes ❑ No
Reaction on skin to cold	❑Yes ❑ No
Dizzy Spells	❑Yes ❑ No
Diabetes	❑Yes ❑ No
Fractures	❑Yes ❑ No

Are you currently experiencing, or have recently experienced any of the following recently:

Fever	❑Yes ❑ No
Chicken Pox	❑Yes ❑ No
Unexplained Rash	❑Yes ❑ No
Unexplained Weight Loss	❑Yes ❑ No
Chronic Fatigue	❑Yes ❑ No
Night Sweats	❑Yes ❑ No
Coughing up blood	❑Yes ❑ No
Meningitis	❑Yes ❑ No
Painful, Swollen Salivary Glands	❑Yes ❑ No
Shingles	❑Yes ❑ No

Are there any other medical conditions not listed above that apply to you?_____
_____

Are you Allergic to any of the following below:

Latex	❑Yes ❑ No
Rubber	❑Yes ❑ No
Tape	❑Yes ❑ No

Other:_____

Signature of Patient/Parent or Legal Guardian_____***Date***____/____/_____

MARKETPLACE POLICIES AND PROCEDURES

By signing below, you acknowledge that you have received this notice and understand these policies:

$50.00 No Show and Short Notice Cancellation Fee

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, *Marketplace Physical Therapy reserves the right to charge a fee of $50.00* for all missed appointments ("no shows") and appointments which, absent a compelling reason, are not canceled with a 24-hour advance notice.

- **"No Show"/ Short notice cancellation fee of $50.00 will be billed to the patient. *This fee is not covered by insurance*.**
- ***If you consecutively no show or cancel 3 scheduled appointments it may result in termination from our care.***

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

_____

Patient Initials

10 MINUTE LATE APPOINTMENT ARRIVAL

As a courtesy to you and other patients it is vital that you arrive at your scheduled appointment on time.

- ***If you show up past the 10 minute mark of your scheduled appointment time for any reason, we will have to reschedule your appointment for another day/time.***
- ***We cannot guarantee that you will be treated even if you call ahead to inform us of your late arrival.***

_____

Patient Initials

PATIENT MISCONDUCT AND HARASSMENT POLICY

Marketplace Physical Therapy will not allow any of its employees to be *physically abused, verbally abused or sexually harassed*. Any display of this behavior will result in a warning or full discharge from all of our clinic locations.

_____

Patient Initials

PATIENT FINANCIAL RESPONSIBILITY

Please read the entire form carefully, then sign and date at the bottom.

Know Your Benefits: Marketplace Physical Therapy verifies your insurance coverage as a courtesy to you and is not a guarantee that the services will be covered. It is the patient's responsibility to know what your insurance does and does not cover. The actual out of pocket expense may be less or greater than the amount estimated and collected. If the information provided by your insurance company is not accurate you may be billed for the outstanding amount or reimbursed if we have collected too much.

_____

Patient Initials

Insurance Coverage: It is the patient's responsibility to inform Marketplace Physical Therapy in a timely manner of any changes in insurance. Failure to do so could cause a delay or denial of insurance payment. Dates that are not covered by your new plan may result in a large outstanding balance that will be the patient's responsibility.

_____

Patient Initials

Patient Payment Responsibility:

- Patient is responsible for an estimated copay/coinsurance amount of $_____ per visit. Payment is due at the time services are rendered.

Financial Agreement:

I understand that insurance claim forms will be submitted to my insurance company as a matter of convenience only, and that I am primarily responsible for all charges regardless of my existing medical coverage.

1. I hereby give authorization for payment of insurance benefits to be made directly to Marketplace Physical Therapy for services rendered.
2. I understand that I am financially responsible for all charges not paid by my insurance company. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees.
3. I hereby authorize this health care provider to release all information necessary to secure the payment of benefits.
4. I further agree that a photocopy of the agreement is as valid as the original.
5. In the event that my insurance company is not paying my claims I will participate in helping Marketplace Physical Therapy get these claims paid.
6. Workers Compensation patients are not responsible for services rendered unless your claim is denied mid treatment.

I request that my records, diagnosis, and any other information needed concerning my accident/injury/illness, be released to Marketplace Physical Therapy, its representatives and the treating physician for reporting purposes.

Authorization for Treatment

I hereby consent to and authorize all therapy treatments, which in conjunction with the judgment of the attending physician may be considered necessary or advisable for the diagnosis or treatment for the above named patient at Marketplace Physical Therapy

Signature of Patient/Parent or Legal guardian:_____Date:___/___/_____