New Patiant Information Form

SAWTOOTH Physical Therapy

First Name _____ MI ___ Last Name _____

Date of Birth _____ Social Security # _____ Gender

Mailing Address _____ ☐ Male ☐ Female

_____

_____

Physical Address _____

_____

_____ Driver's Lic # _____

		OK To Call	Best Time To Call
Home Phone	_____	☐	_____
Work Phone	_____	☐	_____
Cell Phone	_____	☐	_____

Marital Status
- ☐ Divorced
- ☐ Separated
- ☐ Married
- ☐ Single
- ☐ Unknown
- ☐ Widowed

Employment Status
- ☐ Active Military
- ☐ Full-Time
- ☐ None
- ☐ Part-Time
- ☐ Retired
- ☐ Self Employed

Student Status
- ☐ Full-Time
- ☐ None
- ☐ Part-Time

Email Address _____

How would you like to receive Appointment Reminders?
☐ Text ☐ Email

Patient Employer _____
Address _____
_____
Phone _____
Occupation _____

Spouses Employer _____
Address _____
_____
Phone _____
Occupation _____

How did you hear about us?

- ☐ Physician
- ☐ Employer
- ☐ Case Manager
- ☐ Former Patient
- ☐ Adjustor
- ☐ School
- ☐ Hospital
- ☐ Cross Referral
- ☐ Attorney
- ☐ Self
- ☐ Screens - Open Houses
- ☐ Marketing Ad - Print
- ☐ Marketing Ad - TV
- ☐ Marketing Ad - Billboard
- ☐ Marketing Ad - Direct Mail - Email

Specify: _____ ☐ Friend/Family - Please list Name: _____

_____ _____

Signature of Patient Date

Run Analysis Medical History

Welcome to Sawtooth Physical Therapy LLC. Please take a moment to fill out your medical history as accurately as possible. Our goal is to ensure that you receive the best and most complete care possible, and this information is vital for us. Please write clearly and be aware that your therapist may verbally review this information with you.

Name: _____ Date of Birth:_____ Male Female

Height_____ Weight_____

What is your running history? : _____

Weekly running mileage: _____ Other Workout Preferences: _____

Other Events that you do: _____

What injuries or issues have you had? (Include any running or non-running injuries): _____

_____

Date of injury: _____ Date of Surgery: _____

What would you like to learn from this running analysis? _____

_____

Do you have anything in your health history that we need to know about? : _____

_____

Have you recently experienced any of the following conditions?

	YES	NO		YES	NO
Weight Loss or Gain			Nausea or vomiting		
Fatigue			Fever/Chills/Sweats		
Weakness			Vision or Hearing Problems		
Bowel/Bladder Problems			Balance Problems		
Difficulty sleeping			Shortness of breath		

Do you smoke? If YES, how many packs per day? _____

Do you drink alcohol? If yes, how often? Daily Weekly Occasionally

Have you ever been diagnosed with any of the following conditions? Please check appropriate box

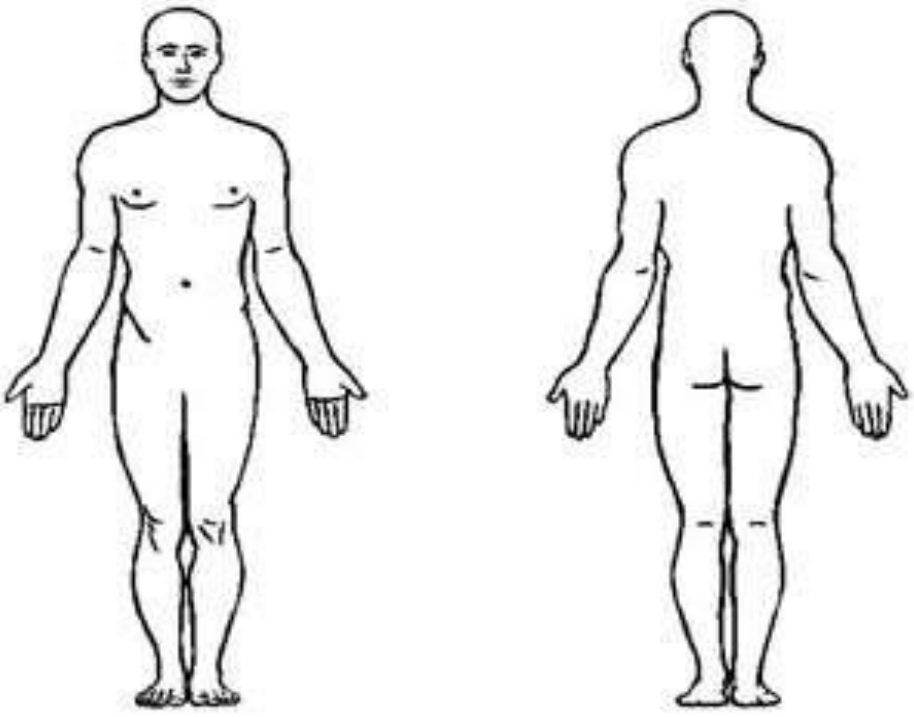
	YES	NO		YES	NO
Cancer			Rheumatic Arthritis		
Heart Problem			Other Arthritic Conditions		
High Blood Pressure			Anemia		
Circulation Problems			Depression		
Asthma			Hepatitis		
Emphysema/Bronchitis			Tuberculosis		
Chemical Dependency			Stroke		
Thyroid Problems			Kidney Disease		
Diabetes			Epilepsy/Seizures		
Multiple sclerosis			Fibromyalgia		
Osteoporosis			Other		
Parkinson's					

Is there any other information that would assist us in your care?

_____

Locate:

Please use the diagram below to mark where you are having pain. Please be specific.



SAWTOOTH
Physical Therapy

Consent for Treatment

I, the undersigned, do hereby agree and give my consent for Sawtooth Physical Therapy LLC to furnish medical care and treatment as considered necessary and proper in diagnosing and treatment for my physical condition. I agree to promptly inform Sawtooth Physical Therapy LLC of any changes to this medical history.

Patient or Guardian Signature: _____Date:_____

Therapist Signature: _____Date:_____

MEDICAL INFORMATION MAY BE RELEASED TO: SPOUSE: _____

PARENT: _____OTHER: _____

PLEASE READ AND SIGN THE FOLLOWING:

I authorize the payment of insurance benefits to Sawtooth Physical Therapy LLC. I authorize the release of any information to and from any medical facilities, physicians, my insurance company, and to any person listed above in the medical information release section. I further agree that a photocopy of this agreement shall be as valid as the original. My signature below acknowledges that I have been offered a copy of the **Notice of Privacy Practices** for Sawtooth Physical Therapy LLC, and have been given a copy if requested. I agree to notify the office of any changes to my address, phone number, employment, and insurance. I understand that as a courtesy to all patients in the clinic, if I am more than 10 minutes late for an appointment it may be rescheduled and if a cancelation is not made at least 24 hours prior to a scheduled appointment, a $25 dollar charge will be submitted to my account. Furthermore I understand that I will be charged $50 for not showing to an appointment and I understand that multiple No-shows' or rescheduled appointments may be grounds for dismissal.

I acknowledge and understand that electronic communication may be used as a form of communication to and from patients of Sawtooth Physical Therapy. I understand that I have the right to communicate electronically to Sawtooth Physical Therapy staff and therapist.

I HAVE READ THE ABOVE INFORMATION ON THIS SHEET AND HAVE AGREED:

SIGN HERE:_____DATE:_____

Patient/Guardian Signature

Financial Policy Statement

Thank you for choosing Sawtooth Physical Therapy LLC for your physical therapy needs. The following is our Financial Policy. If you have any questions or concerns about our payment policies, please do not hesitate to contact our billing office.

We ask that all patients read and sign the Financial Policy. All patients must have one form of picture identification such as a valid driver's license.

Insured Patients:

Sawtooth Physical Therapy LLC will bill your insurance company solely as a courtesy to you. I understand that I am responsible for the entire account, less any insurance contractual agreements, when services are rendered. **Sawtooth requires that payment of your estimated share, including contractual co-pay's be made at the time of service.** In the event your insurance company requests a refund of payments made, you will be responsible for the amount refunded to your insurance company.

I hereby authorize my health insurance company to make payment directly to Sawtooth Physical Therapy LLC for any benefits I may receive. I realize that this may not represent the full payment for services rendered and that I will be held responsible for the balance due within 90 days.

I authorize release of any information necessary to process my insurance claims and facilitate payment of my account by a third party.

Cash Patients:

Full Payment for services is due at the time of services are rendered.

Workers Compensation:

If you are requesting we bill "Workers Compensation" for an established claim, please be advised that should your claim be denied, you will be responsible for the total amount of charges for services rendered to you.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be held responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees. Additionally, I understand that if I pay with a check, and it is subsequently dishonored, I will be responsible for the payment plus and bank processing fees incurred by ***Sawtooth Physical Therapy LLC.***

Patient/Guardian Signature: _____ Date: _____