WELCOME and thank you for choosing **Core Physical Therapy**.

We appreciate the opportunity to provide you with the highest quality physical therapy available. Your commitment to your rehabilitation program is critical to your success. We will recommend treatment and set goals with you. In order to reach those goals, we ask that you do your part by attending every scheduled appointment and performing the exercises at home that will be given by your therapist. We provide services Monday through Friday and will work with you and your schedule to ensure your needs are met.

We will schedule your appointments after your initial evaluation and will provide you with a calendar. You will also be given a reminder when you check out at each visit. If you misplace your schedule, please call us to review dates and times. Your time and the therapist's time is valuable, being late by more than 10 minutes will require you to either reschedule or wait for the next available opening. If you fail to show or cancel for three consecutive visits, our office staff will be required to remove any future appointments scheduled. Your physician and case worker/ adjustor (if you are under a worker's compensation claim) will be notified also.

Here at **Core Physical Therapy** we aim to make your therapy a positive experience. We will verify your insurance benefits and eligibility before services begin. We ask that you do the same as occasionally the information we receive isn't accurate and if the insurance company pays differently than what we were told, you, the patient, will be responsible for the difference. A Core P.T. staff member will contact you to discuss your benefits before your initial appointment or will go over your benefits on your initial appointment date. Many insurances require a copay or coinsurance. All copays or coinsurances will be due at check-in unless alternate arrangements have been made with our billing office staff.

Please go to our website for more information about our practice.
www.corephysicaltherapy.org

101 Stillwater Circle ~ Bonaire, GA 31005 ~ (478) 293-1680

CORE PHYSICAL THERAPY

Last Name _____ **First Name** _____ **Age** _____ **Gender** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Home Phone (_____) _____ **Cell or Work Phone** (_____) _____ **Email Address** _____

Occupation _____ **Employer Name** _____ **Phone #** _____

Emergency Contact Person/Relationship _____ **Phone #** _____ **(If minor) Parent/Guardian Name & Signature** _____

Employment Status: ☐ **Full-time** ☐ **Part-time** ☐ **Unemployed** ☐ **Retired**

My condition is related to: ☐ **Work** ☐ **Auto Accident** ☐ **Other** _____ **Injury Date:** ___/___/___

Social Security # _____ **Date of Birth**_____/_____/_____ ☐ **Single** ☐ **Married**

How did you hear about us? _____**Referring Physician**_____

Primary complaint: _____ **Primary Care Physician**_____

Have you been treated by another (please circle all that apply) physical therapist, chiropractor, or Home Healthcare agency since January 1st of this year? ☐ Yes ☐ No If yes, have you been discharged from their facility? ☐ Yes ☐ No

Primary Insurance Information

Health Insurance _____ Insurance Phone # _____
Group # _____Policy or ID Number _____
Primary Insured/SPONSOR Name _____ Insured date of birth _____
Relationship to Insured _____ Insured phone # _____
Insured address if different from patient:
Street_____
City, State ZIP Code_____

Secondary Insurance Information

Health Insurance _____ Insurance Phone # _____
Group # _____Id Number _____
Primary Insured/ SPONSOR Name _____Insured date of birth _____
Relationship to Insured _____ Insured phone # _____
Insured address if different from patient:
Street _____
City, State ZIP code_____

The above information is true to the best of my knowledge. I, the undersigned, acknowledge that Core Physical Therapy will use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices (HIPAA)

Signed: _____Date:_____

Core Physical Therapy Medical Screening Questionnaire

Date:	Gender: ☐ M ☐ F	Occupation:
Name:	Smoker: ☐ Y ☐ N	
Age:	Pregnant: ☐ Y ☐ N	

Past medical history: Please circle each condition that you have

☐ Cancer ☐ Diabetes ☐ Kidney Disease ☐ Fibromyalgia
☐ High Blood Pressure ☐ Heart Disease ☐ Angina/ Chest Pain ☐ Ulcers
☐ Osteoporosis ☐ Osteoarthritis ☐ Rheumatoid Arthritis ☐ Stroke
☐ Allergies/Asthma ☐ Lung Disease ☐ Liver Disease ☐ Seizures
☐ Multiple sclerosis ☐ **Electrical Implant**
☐ Other: _____

Do you take blood thinners? ☐ YES ☐ NO Are you allergic to Latex? ☐ YES ☐ NO

Have you had a recent illness/surgeries?_____

Orthopedic injuries:_____

Past surgical history: Please list with date_____

_____

_____

Please list all current medications or provide list and we will make a copy:

_____

_____

Currently I am experiencing (circle all that apply):

☐ Fever/Chills/Sweats ☐ Poor Balance (Falls) ☐ Unexplained Weight Loss ☐ Headaches
☐ Nausea/Vomiting ☐ Numbness/Tingling ☐ Changes in Appetite ☐ Depression
☐ Shortness of Breath ☐ Dizziness ☐ Difficulty Swallowing
☐ Changes in Bowel or Bladder Function ☐ Increased Pain at Night

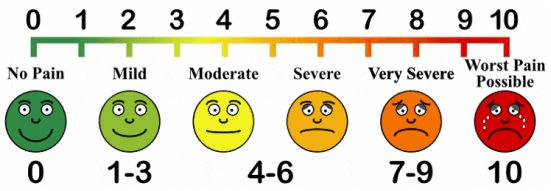
Describe your regular exercise activities:_____

What are your goals for physical therapy?_____

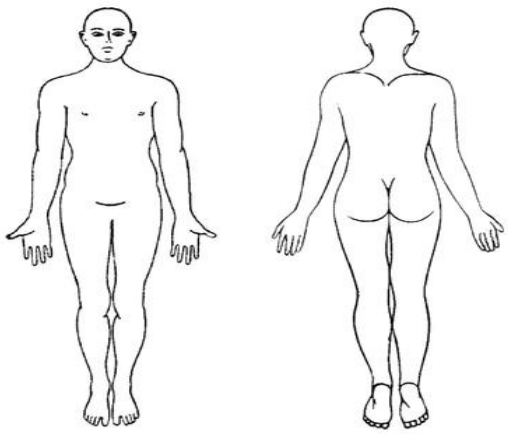
PAIN AND BODY CHART:

Lastly, rate your pain in **the last 48 hours** using the scale below.

Average pain = _____
Worst pain = _____
Lowest pain = _____



Please shade the areas where you feel pain on the chart below.
Mark the chart with X's where you feel tingling or numbness.



IMPORTANT COMPANY POLICIES FOR A SUCCESSFUL RELATIONSHIP

Core Physical Therapy strives to provide you the best personalized care available. To make this possible we adhere to a set of very important guidelines. Please read them carefully, initial all the boxes, and indicate your agreement by signing at the bottom.

Initial All Boxes

☐ **Late Policy "10-minutes"**
Being late by more than 10 minutes will require you to either reschedule, wait for the next available opening, or your treatment time may be reduced.

☐ **Copays are due upon arrival**
We will file your insurance; however, you are responsible for paying your deductible, co-pay, and/or percentage at the time of service unless arrangements are made in advance. We accept cash, checks, and all major credit cards. There will be $25.00 service charge for all returned checks. You may prepay for the week or at each appointment.

☐ **No-shows/ Cancellations Fee**
Not showing for a scheduled appointment or cancelling without 24 hours notice will result in a $25 charge that will be billed to you directly. If you fail to show or cancel for three consecutive visits, our front office staff will be required to remove all future appointments scheduled. Your physician and adjustor/ case worker (if you are under a worker's compensation claim) will be notified.

☐ **Insurance changes**
It is your responsibility to notify our front office of all insurances and of any changes that may occur during your care. All charges that occur due to insurance conflicts will be the responsibility of the patient.

☐ **Consent for Treatment**
I consent to and authorize Core PT (including students in training) to administer physical therapy treatment under the direction and supervision of the physical therapist. I understand and am informed that, as in the practice of medicine, physical therapy may have some risks. I understand that I have the right to ask about these risks and have any questions about my condition answered prior to treatment. I know it is up to me to inform the physical therapist/staff about any health problems or allergies I have, as well as medications I am taking. I understand that no contract, guarantee, warranty, or promise concerning the results of the physical therapy services is made.

☐ **Children**
Children under 12 may not be left unattended in waiting room. Also, if a child must accompany you into therapy, please be considerate of other patients and their therapy time.

☐ **Cell phones must be shut off or silenced.**
We realize emergencies may arise and therefore allow you to carry your cell phone during your session, however, please be courteous and set to silent mode or turn off. Please refrain from carrying on phone conversations in treatment areas out of respect for other patients. Thank you.

I HAVE READ AND AGREE TO CORE PT's POLICIES LISTED ABOVE.

Patient signature_____ **Date** _____

Assignment of Benefits Statement & Medical Release

_____ _____

Patient Name Date of Birth

Authorization For Release Of Medical Information And Assignment Of Benefits

For consideration of services rendered by Core Physical Therapy, I hereby guarantee payment of all charges incurred by above named patient. I hereby authorize the payment of benefits of my insurance policy to be paid directly to Core Physical Therapy, for services rendered. I further authorize this office to release/receive any information acquired in the course of my examination and treatment to my insurance company, other physicians, hospital, clinics or Core Physical Therapy.

I authorize Core Physical Therapy to release information regarding my care/treatment to the following family members (Spouse, children, siblings): _____
I GIVE / DO NOT GIVE (please circle) my permission to Core PT to leave confidential/ non-confidential (please circle whichever applies) messages at HOME, CELL, WORK.
How would you like your reminder sent to you? Email/Text (Please circle one)
What is your cell phone provider?_____
(Standard messaging rates apply and are to be paid by the patient.)
Consent for email communications: Yes/No (please circle)

It is the patient's responsibility to keep personal items with them at all times.

As a service to you, our office will bill your primary and 2nd insurance companies for charges incurred. All deductibles, copays, and coinsurance balances will be due on the date services are rendered at check-in.

We DO NOT file 3rd party claims here at Core Physical Therapy. If you are being seen in our office for injuries sustained in an auto accident, we will file your personal insurance and copays, coinsurances, & deductibles must be paid as if the treatment was not due to an auto accident.

The parent or guardian accompanying a minor is responsible for payment of services at the time of check-in. Unaccompanied minors (under 18) still must have payment at time of service unless the parent or guardian has signed patient and financial responsibility forms.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT PAID BY MY INSURANCE COMPANY. All patients **without insurance** will be required to pay in full at the time of service. Credit cards, cash, & checks will be accepted.

_____ _____ _____

PATIENT NAME (PLEASE PRINT) PATIENT SIGNATURE DATE SIGNED

_____

RESPONSIBLE PARTY SIGNATURE (if other than patient)

PATIENT CANCELLATION AND "NO SHOW" POLICY

Thank you for choosing Core Physical Therapy as your physical therapy provider

We are dedicated to helping you meet your therapy goals. In order to do this, it is important that you attend all scheduled therapy appointments. Consistent attendance allows you and your therapist to progress your treatment program, which will result in quicker recovery and better outcomes.

We realize that there are times when unforeseen circumstances make it impossible to attend your scheduled appointment. If this happens, we ask that you show us consideration by calling at least 24 hours prior to your appointment so we can reschedule your appointment and open that time slot for another client. You may leave a message **at 478-293-1680**, if you are calling after hours**.** Cancelling an appointment with short notice or no showing an appointment takes up clinic time that could benefit another person.

In order to enforce this policy, you will be charged $25 if you cancel less than 24 hours in advance or no show for your appointment. This fee cannot be billed to your insurance company and we will be your direct responsibility. "No-Showing" or cancelling appointments without a 24-hour notice 3 times will limit your ability to schedule advanced appointments. Core PT reserves the right to waive fee and honor charges at its discretion.

Work Comp Patients

In the event that you are covered by workers' compensation and fail to keep the appointments as recommended by your physician, the appropriate parties WILL BE NOTIFIED OF YOUR ABSENCE IN WRITING. Typically, the notification will be to your physician, insurance carrier, and employer and rehabilitation consultant. Each cancelled and "no show" appointment will also be noted in your chart. Failure to attend therapy may have a negative effect on your workers' compensation coverage.

We regret having to implement this policy, however due to the high rate of last minute cancellations and patient "no-shows" it has become necessary that we make this change. We value all of our patients and we hope you will understand that in the interest of fairness it is important to have advance notice of cancellations so that those spots may be used by other patients.

WE THANK YOU FOR RESPECTING THIS POLICY.

I, the undersigned, understand the *Patient Cancellation and No Show Policy* described above.

_____ _____

Patient Signature Date

_____ _____

Witness Date