Wise Physical Therapy and Rehabilitation
2612 Eagle Street
Anchorage, AK 99503
Phone (907) 562-2118 * Fax 562-2128

_____
(Last name, first initial)

_____
(dob)

_____ _____ ____ _____
First Name Last Name MI Social Security #

Nick-name _____

O Male
O Female
_____
Birth Date

O Married
O Single
O Other

Select One: **O** FT Student **O** FT Employed **O** PT Student **O** PT Employed **O** Unemployed

Physical Address: _____

City/St/Zip: _____

Mailing Address (if different): _____

City/St/Zip: _____

Email Address _____

Home Phone _____ Work Phone _____

Cell Phone _____ Fax Number _____

Appointment Reminders:

Do you want to receive apt. reminders? O Yes O No

What phone # do you prefer to be contacted at? Hm / cell / wk (select one)

Is it ok to leave message? O Yes O No

Would you like email reminders? O Yes O No

Would you like text reminders? O Yes O No

Spouse / Guardian Information

Name: _____

Relationship: _____

Address: _____

City/St/Zip: _____

Phone Number: _____

Emergency Contact information

Name: _____

Relationship: _____

Address: _____

City/St/Zip: _____

Phone #: hm/cell/wk _____

Person Responsible for Bill

Name: _____

Relationship: _____

Address: _____

City/St/Zip: _____

Phone Number: _____

Employer

Employer:_____

Occupation: _____

Address: _____

City/St/Zip: _____

Phone Number: _____

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Is this a job related injury? O Yes O No

Employer:_____

Insurance: _____

Claim #: _____

Claim Adjustor Name: _____

Phone Number: _____

Is this a motor vehicle accident injury? O Yes O No

Insurance Company:_____

Claim #: _____

Insured Name: _____

Claim Adjustor: _____

Phone Number: _____

Is there an attorney involved? O Yes O No

Attorney:_____

Address: _____

City/St/Zip: _____

Phone Number: _____

PRIMARY PHYSICIAN

Name:_____

Clinic: _____

Phone Number: _____

Primary Insurance? O Yes O No

Company:_____

Policy #: _____

Group #: _____

Patient's relationship to Subscriber [ ] Self [ ] Spouse

[ ]Parent [ ] Other _____

If other than self:

Subscribers Name: _____

DOB_____ SS#_____

Secondary Insurance? O Yes O No

Company:_____

Policy #: _____

Group #: _____

Patient's relationship to Subscriber [ ] Self [ ] Spouse

[ ]Parent [ ] Other _____

If other than self:

Subscribers Name: _____

DOB_____ SS#_____

I understand that I am responsible for my physical therapy charges and I agree to pay in a timely manner my deductible, co-insurance or co-payment and any charges not reimbursed by my insurance carrier. I authorize Wise Physical Therapy to bill my insurance company and I authorize payment from the insurance carrier directly to Wise Physical Therapy. I authorize Wise Physical Therapy to release medical or other information necessary to process this claim.

I understand and agree that health and accident insurance policies are an agreement between an insurance company and myself. I understand that some insurance companies have deductibles, co-pays, and/or require medical or administrative preauthorization for treatment. *I understand that I am responsible for knowing and meeting the requirements of my insurance plan*. Wise Physical Therapy is not responsible for incorrect information given by my insurance carrier regarding my benefits.

In the event of my default, I agree that I will be responsible for all costs of collecting amount owed, including but not limited to court costs, collections agency fees, and attorney fees.

(The above may not apply for those patients that are considered Worker's Compensation or who have benefits with a balance billing contract, such as an HMO. However, be advised if you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.)

I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

Printed Name_____

Signature _____ **Date** _____

(Patient/Guardian/Responsible Party)

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CANCELATION FEE / NO-SHOW FEE of $50.00

While we are happy to provide an appointment reminder, is ultimately your responsibility to remember your appointment and arrive in a timely manner. If you can't make an appointment, we request advanced notification of *24 hours*, otherwise a $50.00 cancellation/no-show fee will be applied to your account. If you are late for your appointment you can be noted as a no-show.

You, as an individual, are responsible for the $50.00 fee, not your insurance.

Our goal is to get you better. If "something comes up" please give us a courtesy call and we will be happy to get you rescheduled for a more convenient time.

Initial acknowledgement of cancellation/ no-show fee_____

MEDICAL/PHYSICAL CHANGES/UPDATES

It is important that all changes are shared right away with the therapist. In order to provide you with appropriate care we must know when you are seeing a new doctor, chiropractor, etc., if you have been in an accident, hurt or re-hurt, or if your medications have been changed in any way. These are just some examples. If you are not sure, please discuss with the therapist for your safety.

Initial acknowledgement of medical changes_____

MEDICARE PATIENTS **Are you on Medicare? O Yes O No** (if no, skip the next question)

If yes, have you received Home Healthcare in the last 30 days? O Yes O No

This information is vital as it does affect the billing portion of your time with us. If you have received home health care in the last 30 days and fail to inform Wise Physical Therapy *you will be solely responsible* for full payments of services received.

Initial acknowledgement of Medicare home health charges_____

Thank you for choosing Wise Physical Therapy for your therapy services. We strive to provide the best care for our patients. The staff will assist you with any area of need. Please do not hesitate to ask for assistance at any time if you do not understand something.

Thank you for your time and cooperation in getting you back to better health!

I have read and agree to the above office policies.

I do hereby agree and give my consent for Wise Physical Therapy to furnish medical care and treatment to me considered necessary and proper in diagnosing or treating his/her/my condition.

Printed Name_____

Signature _____ **Date** _____
(Patient/Guardian/Responsible Party)

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ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

Wise Physical Therapy will use and disclose your personal health information to treat you, to receive payment for treatment we provide and for other healthcare procedures. Healthcare procedures are generally those activities we perform to improve the quality of care. We have prepared a detailed notice of privacy practices to help you better understand our policies about your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities and have copies available for distribution.

I have received a copy of Wise Physical Therapy's Notice of Privacy Practices.

Printed Name_____

Signature _____ **Date** _____
(Patient/Guardian/Responsible Party)

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT
Original completed consent to be filed in patient's medical record

FOR OFFICE USE ONLY

We attempted to receive written acknowledgment of receipt of our notice of Privacy Practices but the acknowledgement could not be obtained because:

[ ] Individual refused to sign

[ ] Communication barriers inhibiting the acknowledgement

[ ] An emergency situation prevented us from obtaining acknowledgment

Other (Please Specify) _____

_____

_____

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MEDICAL HISTORY

Allergies	O Yes	O No	Depression	O Yes	O No	Multiple Sclerosis	O Yes	O No
Anemia	O Yes	O No	Diabetes	O Yes	O No	Osteoporosis	O Yes	O No
Anxiety	O Yes	O No	Dizzy Spells	O Yes	O No	Parkinsons	O Yes	O No
Arthritis	O Yes	O No	Emphysema/Bronchitis	O Yes	O No	Rheumatoid Arthritis	O Yes	O No
Asthma	O Yes	O No	Fractures	O Yes	O No	Seizures	O Yes	O No
Cancer	O Yes	O No	Gallbladder Problems	O Yes	O No	Strokes	O Yes	O No
Cardiac Conditions	O Yes	O No	Hepatitis	O Yes	O No	Thyroid Disease	O Yes	O No
Cardiac Pacemaker	O Yes	O No	High Blood Pressure	O Yes	O No	Tuberculosis	O Yes	O No
Chemical Dependency	O Yes	O No	Incontinence	O Yes	O No	Vision Problems	O Yes	O No
Circulation Problems	O Yes	O No	Kidney Problems	O Yes	O No			
Currently Pregnant	O Yes	O No	Metal Implants	O Yes	O No			

Describe any other conditions or precautions:

Fall History

Is the injury as a result of a fall in the past year? **O Yes O No** Date of Fall:_____

Two or more falls in the last year? **O Yes O No** Dates of Falls:_____

Surgical History

Body Region: _____ Surgery Type: _____Date of Surgery:_____

Body Region: _____ Surgery Type: _____Date of Surgery:_____

Body Region: _____ Surgery Type: _____Date of Surgery:_____

Body Region: _____ Surgery Type: _____Date of Surgery:_____

Body Region: _____ Surgery Type: _____Date of Surgery:_____

Current Medications: prescribed and over-the-counter

Drug: _____ Dosage: _____ Reason for Taking:_____

Drug: _____ Dosage: _____ Reason for Taking:_____

Drug: _____ Dosage: _____ Reason for Taking:_____

Drug: _____ Dosage: _____ Reason for Taking:_____

Drug: _____ Dosage: _____ Reason for Taking:_____

Printed Name_____

Signature _____ **Date** _____
(Patient/Guardian/Responsible Party)