Wise Physical Therapy & Rehabilitation

1200 Airport Heights Drive, Ste 170
Anchorage, AK 99508
Phone (907) 562-2118
Fax (907) 562-2128

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 appointment reminders? O Yes O No

What phone # do you prefer to be contacted at? Home / Cell / Work (circle one)

Is it ok to leave message? O Yes O No

Would you prefer to be emailed reminders? O Yes O No

Would you prefer to be texted 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: ______

Wise Physical Therapy & Rehabilitation

1200 Airport Heights Drive, Ste 170
Anchorage, AK 99508
Phone (907) 562-2118
Fax (907) 562-2128

Is this a job related injury? O Yes O No

Date of Injury:______________________________

Employer:______________________________

Insurance: ______________________________

Claim #: ______________________________

Claim Adjustor Name: ______________________________

Phone Number: ______________________________

Is there an attorney involved? ______________________________

Attorney name:______________________________

Phone Number:______________________________

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

Date of Accident:______________________________

Insurance:______________________________

Claim #: ______________________________

Insured Name: ______________________________

Claim Adjustor: ______________________________

Phone Number: ______________________________

Is there an attorney involved? ______________________________

Attorney name:______________________________

Phone Number:______________________________

PRIMARY PHYSICIAN

Name:______________________________

Clinic: ______________________________

Phone Number: ______________________________

REFERRAL 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)

Wise Physical Therapy & Rehabilitation

1200 Airport Heights Drive, Ste 170
Anchorage, AK 99508
Phone (907) 562-2118
Fax (907) 562-2128

CANCELLATION 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. 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)

Wise Physical Therapy & Rehabilitation

1200 Airport Heights Drive, Ste 170
Anchorage, AK 99508
Phone (907) 562-2118
Fax (907) 562-2128

NOTICE OF PRIVACY PRACTICES AND YOUR HEALTH INFORMATION

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 this Notice may change with time and we will always have the current notice posted at our facilities, as well as have copies available for you that you can request at any time.

The included pamphlet notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you have any questions about this notice, please contact us.

This notice is effective as of January 1, 2015.

By signing this, I am acknowledging that I have received and read this Notice of Privacy Practices.

Printed Name____

Signature ____ **Date** __________________________

(Patient/Guardian/Responsible Party)

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)
____
____

Wise Physical Therapy & Rehabilitation

1200 Airport Heights Drive, Ste 170
Anchorage, AK 99508
Phone (907) 562-2118
Fax (907) 562-2128

CURRENT COMPLAINT(S)

Overall, my health is (circle one): Excellent, Good, Fair, Poor, other-explain:

List your top health goals, in order of importance:

1.

2.

3.

4.

5.

List your symptoms, in order of importance:

1.

2,

3.

4.

5.

List all doctors or other health practitioners you have seen for this problem:

1. Provider's name: date of last visit:

2. Provider's name: date of last visit:

3. Provider's name: date of last visit:

List anything else you have tried in order to resolve this problem

1.

2.

EXPECTATIONS

How long do you expect it to take to fully resolve your health?

What lifestyle changes do you think you will have to make in order to achieve your health goals?

On a scale of 1-10, how important is it for you to improve this situation?

Unimportant 1 2 3 4 5 6 7 8 9 10 I'd do anything to fix this!

Wise Physical Therapy & Rehabilitation

1200 Airport Heights Drive, Ste 170
Anchorage, AK 99508
Phone (907) 562-2118
Fax (907) 562-2128

MEDICAL HISTORY

Condition		Condition		Condition	
Allergies	O Yes O No	Dizzy Spells	O Yes O No	MRSA – Staph Infection	O Yes O No
Anemia	O Yes O No	Emphysema/Bronchitis	O Yes O No	Multiple Sclerosis	O Yes O No
Anxiety	O Yes O No	Fibromyalgia	O Yes O No	Muscular Disease	O Yes O No
Arthritis	O Yes O No	Fractures	O Yes O No	Osteoporosis	O Yes O No
Asthma	O Yes O No	Gallbladder Problems	O Yes O No	Parkinson's Disease	O Yes O No
Autoimmune Disease	O Yes O No	Headaches	O Yes O No	Rheumatoid Arthritis	O Yes O No
Cancer	O Yes O No	Hearing Impairment	O Yes O No	Seizures	O Yes O No
Cardiac Conditions	O Yes O No	Hepatitis	O Yes O No	Smoking	O Yes O No
Cardiac Pacemaker	O Yes O No	High Cholesterol	O Yes O No	Speech Problems	O Yes O No
Chemical Dependency	O Yes O No	High Blood Pressure	O Yes O No	Stroke	O Yes O No
Circulation Problems	O Yes O No	HIV/AIDS	O Yes O No	Thyroid Disease	O Yes O No
Currently Pregnant	O Yes O No	Incontinence	O Yes O No	Tuberculosis	O Yes O No
Depression	O Yes O No	Kidney Problems	O Yes O No	Vision Problems	O Yes O No
Diabetes	O Yes O No	Metal Implants	O Yes O No		

Describe any other conditions:

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** ____________________________

NAME: ____ DATE:

DOB:____________________

Where is your pain?

Please mark on the drawings below the areas you feel your pain.