Patient Information Sheet

Date: _____

Name: _____ Birth Date: _____

(First) (Last) (Middle Initial)

Mailing Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Preferred method of communication for patient reminders: ☐ Call ☐ Text Cell phone carrier: _____

I recognize that normal text messaging rates may apply. Signature _____

Employer: _____ Job Title/Description: _____

Name of Spouse/Partner (or Parent if Minor): _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Referring Physician: _____ Primary Physician: _____

Medical History

Condition/Injury Related to: ___ Work ___ Auto ___ Sport ___ Other: _____

Date of Onset, Injury and/or Surgery: _____

Date of Last Doctor Visit: _____

Motor Vehicle Accident Information (Fill Out Only If Applicable)

Personal Injury Protection (PIP) ___ Yes ___ No Company Name: _____

Company Contact Information: _____

For Office Use Only

Is this patient a returning patient? ___ Yes ___ No

How did patient hear about our clinic for this injury or problem?

___ Doctor Recommendation Name: _____

___ Friend/Family Member Name: _____

___ Internet Website/Search Engine: _____

___ Phone Book Area and Category: _____

___ Other Specifically: _____

Picture ID Verified: ___ Yes ___ No Initials: _____ If no, why: _____

Cancellation & No-Show Policy

Thank you for choosing Gordon Physical Therapy for your Physical Therapy needs. We are looking forward to working with you to help you achieve your goals! After your first appointment, we will attempt to schedule out your entire treatment plan ahead of time to ensure your desired time slots are reserved well in advance.

Should you need to change your appointment, we ask that you call at least **24 hours** prior to your scheduled appointment time. A 24-hour notice gives our front desk team adequate time to reach out to any other clients needing our help that may be waiting for an available appointment time.

With this being said, our official Cancellation & No-Show Policy is as follows:

A 24-hour notice by phone is required by our clients for any cancellations or changes to an appointment. If you fail to give us a 24-hour notice, there is no immediate penalty, as we at GPT know that there are good reasons to cancel or reschedule an appointment at times. However, if there are three occurrences in which you fail to give us a 24-hour notice, we will no longer schedule your appointments in advance, and any remaining visits will be taken off the schedule. You will be placed on our "Same Day List," meaning that if you want an appointment, you must reach out to us the same day you would like to be treated, in hopes there will be an opening in our schedule that works for you.

If you are an injured worker, we are also required to notify your health care provider and claims manager if more than one cancellation or no-show occurs.

In addition, any late arrivals to your appointment may require us to reschedule or cancel the appointment. A scenario like this is also counted as a last-minute cancellation.

Thank you again for choosing Gordon PT! We'll do our very best to accommodate your scheduling needs so that we can help you achieve your goals!

By Signing below, I acknowledge and understand the policies stated above.

Name of Client or Guardian Printed: _____

Signature of Client or Guardian: _____ *Date* _____

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Office & Financial Policies

Patient Name: _____ Date: _____

- Please bring all your current insurance and claim information, as well as photo identification, to every visit.
- Insurance coverage is never guaranteed. Your insurance company determines benefits when claims are received. Any written or verbal information regarding your coverage provided to you by our staff in no way guarantees that your care here will be covered by your insurance company. It is strongly recommended that you personally verify your insurance benefit with your insurance provider prior to receiving care.
- Patients whose care will not be covered in full by insurance are required to make a payment on their account at each time of service. The payment is determined as follows:
    - Co-pay amounts set by your insurance carrier are due in full at each visit
    - Patients with an outstanding deductible less than $500 will be charged $35 at each visit
    - Patients with an outstanding deductible greater than $500 will be charged $50 at each visit
    - Patients with coinsurance will be charged $17 at each visit
    - Payment for supplies such as orthotics, tape or braces are due in full at the time of service
    - Patients without insurance are eligible for our private pay program. Charges must be paid in full at each visit
- Any outstanding balance is due in 30 days after the insurance company has paid. If your insurance company does not pay us, the full amount is due within 90 days after the date of service.
- *Account Responsibility: Many people are under the impression that if they have insurance, it is the insurance company that owes Gordon Physical Therapy for their services. This is not the case. The insurance contract is* ***between you and the insurance company;*** *our relationship to you is as a patient to whom we are providing service.*

  Our responsibility:

    - *To bill all claims to your insurance carrier(s) in a timely manner on your behalf*
    - *To assist you in resolving any problems with your claim payment*

  Your responsibility:

    - *To provide us with current and accurate information to submit your claims correctly*
    - *To make certain there is authorization for treatment if it is required by your insurance*
    - *To pay your co-pays, coinsurance or deductible payments at the time of service*
    - *To pay any additional amount owed as determined by your insurance carrier within 30 days of receipt of your first statement from us.*
- Unpaid accounts past 90 days may be sent to a third party collection agency, and may have an additional 1.5% interest charge attached. Additional collection fees and/or attorney fees will be your responsibility.
- A $25 processing fee will be added to all returned checks.
- Your signature below gives us permission to engage in collection of insurance or other 3rd party benefits. You agree to inform our clinic immediately and in writing upon signing any exclusive release of medical records with your attorney, or of any limitation you wish to be placed on release of your medical records.
- Your signature below acknowledges that you have been made aware of our notice of privacy practices.
- Your signature below authorizes direct payment to our clinic by your insurance company or other third party provider.
- Please feel free to ask our Patient Accounts Manager any financial questions you may have. You may call Kathy at 509.534.2837. Our intention is to provide you with the highest level of service and care.

By signing below, I acknowledge and understand the policies as stated above and authorize treatment from the Gordon Physical Therapy.

Signature of Patient or Legal Guardian: _____ Date: _____

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Name: _____ **Today's Date:** _____

Have you recently had the following tests? Yes ____ No____ If **Yes**, check all that apply:

____x-rays ____Bone Scan ____CT Scan ____EMG ____MRI ____Blood Tests

Pain rating: Indicate your average level of pain by circling the appropriate number on the scale below:

0 1 2 3 4 5 6 7 8 9 10

Pain free *Unconscious Pain*

Describe the character of your pain? (What does it feel like...sharp, dull, achy, etc.?)

_____

Is the pain there all the time (constant)? Yes _____ No _____

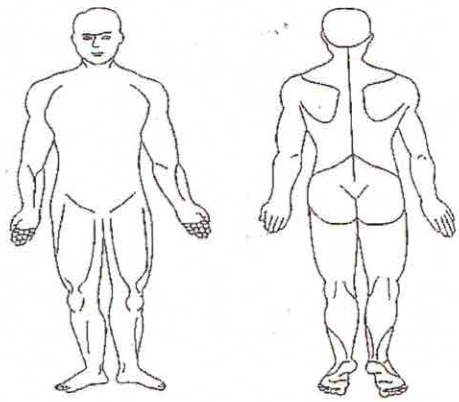
Does the pain move or radiate anywhere? Yes _____ No _____

Do you have numbness, tingling, or weakness? Yes _____ No _____

Location of radiation or numbness _____

Have you had any changes in your bowel, bladder or sexual function as a result of your symptoms? Yes ___ No ____ Describe: _____

_____



Shade Areas of Pain

What activities/positions make your pain worse? _____

_____

What activities/positions make your pain better? _____

_____

Please describe work and social activities: (physical tasks, amount of sitting, lifting, computer work etc.):_____

_____

Please list any other treatments you have tried for this condition: _____

_____

Medication List	**Dosage**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____