

Print clearly, or complete on a computer. Fields with a box can be typed.

1 PATIENT INFORMATION

Patient full name

Date of birth

Phone

Email

Street address

City

State

ZIP

Emergency contact · name and relationship

Emergency contact phone

Referring physician / provider (if any)

Referring provider phone

Primary care provider

Occupation

2 REASON FOR TODAY'S VISIT

Body part or area being treated

When did the problem begin?

Was it caused by an injury?

☐ Yes

☐ No

If yes, briefly describe what happened, and the date

Pain today (0–10)

Best

Worst

0 = no pain 10 = worst pain imaginable

What makes symptoms better?

What makes symptoms worse?

Main goals for physical therapy

Visit type (check all that apply)

☐ Work-related injury

☐ Motor vehicle / PIP

☐ Sports injury

☐ Post-operative rehab

☐ Other

3 MEDICAL HISTORY

Check any that apply. Use the line below for anything not listed, including neurological conditions.

- | | | |
|---|--|---|
| ☐ High blood pressure | ☐ Pregnant | ☐ Previous surgery |
| ☐ High cholesterol | ☐ Pacemaker or implanted device | ☐ Fracture |
| ☐ Diabetes | ☐ Cancer | ☐ Arthritis |
| ☐ Previous injury to this area | ☐ Other medical condition | |

Other relevant history, surgeries, or implants (include neurological conditions here)

Previous physical therapy? ☐ Yes ☐ No If yes, when and where

4 MEDICATIONS AND ALLERGIES

Current medications and supplements (or write "see attached list")

Medication, food, or latex allergies ☐ None known ☐ Yes — list:

Reaction, if any

5 BLOOD FLOW, CIRCULATION, AND SLEEP SCREENING

Check Yes or No for each question. Add a note at the bottom if any answer is Yes.

Blood flow and circulation	Yes	No
1. Do your legs ever feel fatigued, tired, achy, or swollen?	☐	☐
2. Are these symptoms especially noticeable at the end of the day?	☐	☐
3. Do you have visible varicose or spider veins?	☐	☐
4. Do your socks leave noticeable marks or impressions on your skin?	☐	☐
5. Have you noticed decreased or lost hair growth on the lower half of your legs?	☐	☐
6. Have you experienced restless legs or leg cramping?	☐	☐
7. In the past 4 weeks, have leg symptoms interrupted your sleep?	☐	☐
8. In the past 4 weeks, have leg symptoms interrupted walking or sitting?	☐	☐
Sleep health		
9. Do you wake up with headaches?	☐	☐
10. Do you feel excessively tired during the day?	☐	☐
11. Do you ever unintentionally fall asleep during daily activities (TV, work, driving)?	☐	☐
12. Do you have high blood pressure?	☐	☐
13. Do you wake up frequently during the night?	☐	☐
14. Do you have difficulty falling asleep?	☐	☐
15. Do you often feel irritable, forgetful, or have trouble concentrating during the day?	☐	☐
16. Have you ever been diagnosed with sleep apnea or another sleep disorder?	☐	☐

If yes to any question, add details

Patient / legal representative signature

Date

Therapist review / initials

Date

6 INSURANCE INFORMATION

Primary insurance company

Member / subscriber ID

Group number

Policy holder name

Policy holder date of birth

Relationship to patient

☐ Self

☐ Spouse

☐ Parent

☐ Other

Secondary insurance (if any)

Member ID

Group number

I authorize Springfield Physical Therapy & Wellness and its designated providers to submit claims to my insurance company for services provided to me. I authorize my insurance benefits to be paid directly to the provider where permitted. I understand that insurance verification is not a guarantee of payment and that I am responsible for deductibles, copays, coinsurance, non-covered services, denials, and other amounts legally owed by me.

☐ I have provided current insurance information and will notify the office of any change.

☐ I authorize release of information reasonably necessary to process my insurance claims.

☐ I understand I may be asked for identification and insurance information for billing.

7 PAYMENT RESPONSIBILITY

I understand that I am financially responsible for charges associated with my care that are not paid by my insurance or another responsible party. I agree to pay applicable copays, deductibles, coinsurance, self-pay charges, and other patient balances when due. An insurance estimate is not a guarantee of benefits or payment.

☐ Payment is due at the time of service unless other arrangements have been approved.

☐ Missed or cancelled appointments may be subject to the clinic's cancellation policy.

☐ Balances may remain my responsibility if insurance denies or reduces payment.

☐ The clinic may use the payment method I provide for authorized patient balances, if applicable.

Payment method on file, if applicable

☐ Card

☐ Cash

☐ Other

Financial questions or notes

8 PRIVACY AND WHO WE MAY CONTACT

I acknowledge that I have been offered the chance to receive or review the Notice of Privacy Practices, which describes how my protected health information (PHI) may be used and disclosed, my rights regarding my PHI, and the clinic's responsibilities under applicable law.

☐ I received or reviewed the Notice of Privacy Practices.

☐ I was offered a chance to ask questions about the Notice.

☐ I understand I may request restrictions or confidential communications as permitted by law.

Preferred method for routine messages

☐ Phone

☐ Text

☐ Email

☐ Patient portal

Preferred phone or email for those messages

People the clinic may contact about scheduling, billing, or other permitted matters. This does not authorize release of the full medical record.

Name	Relationship	Phone

☐ I do not authorize communication with any additional person.

9 AUTHORIZATIONS, CONSENT, AND FINANCIAL RESPONSIBILITY

Please read each item and check the box to confirm you understand and agree. The full terms below are the clinic's authorization, assignment, privacy acknowledgment, and consent to treat.

☐ **Medicare signature authorization**

I authorize Springfield Physical Therapy & Wellness LLC to release medical or other information about me to the Social Security Administration, Health Care Financing Administration (CMS), their intermediaries or carriers for benefit claims, and I request payment of medical insurance benefits to Springfield Physical Therapy & Wellness LLC.

☐ **Insurance authorization and assignment**

I authorize Springfield Physical Therapy & Wellness LLC to release medical or other information about me to my insurance carrier(s) for benefit claims submitted on my behalf. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to Springfield Physical Therapy & Wellness LLC.

☐ **Terms of payment for services rendered**

I authorize and request that all physical therapy insurance benefits be paid directly to Springfield Physical Therapy & Wellness LLC for services and items provided. I accept legal responsibility for the total fee due and agree that any unpaid balance will be paid by me, even if the insurance allowance is less than the fee charged. Standard fees will be adjusted to the allowable fee schedule set by insurance contracts in which the clinic participates. I understand that I am responsible for applicable collection-agency fees necessary to collect a balance owed and for any returned-check fees due to insufficient funds.

☐ **HIPAA notice acknowledgment**

I acknowledge that I have received the HIPAA Notice of Privacy Practices, which describes the types of uses and disclosures of my protected health information that may occur in my treatment, payment of my bills, or healthcare operations of Springfield Physical Therapy & Wellness LLC, along with my rights regarding my protected health information. Copies of the Notice of Privacy Practices are available at the front desk.

☐ **Consent to treat**

I give my consent for treatment of myself, my minor child, or my dependent by Springfield Physical Therapy & Wellness LLC. This consent remains valid until I notify Springfield Physical Therapy & Wellness LLC in writing otherwise.

Final authorization

By signing below, I acknowledge that I have read, understand, and agree to the authorizations, consent to treat, HIPAA acknowledgment, insurance assignment, and financial responsibility terms on this form.

Patient / responsible party name (print)

Date

Signature

Sign here

Relationship to patient, if you are signing for the patient

FOR OFFICE USE

Received

Therapist

Chart / account

Notes