

WHITE SANDS PHYSICAL THERAPY & AQUATICS

MEDICAL HISTORY

Patient Last Name: _____ **First Name:** _____ **DOB:** _____

Primary Care Physician: _____

Referring Physician or name the doctor who will be signing any reports generated by your therapist: _____

Diagnosis or reason for Physical Therapy: _____

Check all current or past conditions:

Back Pain	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	Tingling in Legs/Feet	<input type="checkbox"/>
Spinal Stenosis	<input type="checkbox"/>	Hysterectomy	<input type="checkbox"/>	Total Knee Replacement	<input type="checkbox"/> L <input type="checkbox"/> R
Back Surgery	<input type="checkbox"/>	Balance	<input type="checkbox"/>	Total Shoulder Replacement	<input type="checkbox"/> L <input type="checkbox"/> R
Disc Problems	<input type="checkbox"/>	Pregnant	<input type="checkbox"/>	Total Hip Replacement	<input type="checkbox"/> L <input type="checkbox"/> R
History of Sciatica	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Cancer: Type _____	<input type="checkbox"/>
History of Scoliosis	<input type="checkbox"/>	COPD	<input type="checkbox"/>	Fear of swimming pool	<input type="checkbox"/>
Knee Pain	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	Open Wound/Sore	<input type="checkbox"/>
Hip Pain	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	Skin Rashes	<input type="checkbox"/>
Shoulder Pain	<input type="checkbox"/>	Depression	<input type="checkbox"/>	Osteoarthritis (Degenerative)	<input type="checkbox"/>
Neck Pain	<input type="checkbox"/>	Memories Issues	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>
Neck Stiffness	<input type="checkbox"/>	Dementia	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	Alzheimer	<input type="checkbox"/>	Osteopenia	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	Diabetes	Type 1 <input type="checkbox"/>	Anemia	<input type="checkbox"/>
Heart Surgery	<input type="checkbox"/>		Type 2 <input type="checkbox"/>		
Pacemaker / Defibrillator	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	Infection Disease	<input type="checkbox"/>
CVA Stroke	<input type="checkbox"/>	Thyroid	Hypo <input type="checkbox"/> Hyper <input type="checkbox"/>	Vision Problems	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	Bladder Urgency	<input type="checkbox"/>	DNR	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	Bladder Incontinence	<input type="checkbox"/>	Metal Implant	<input type="checkbox"/>
Parkinson	<input type="checkbox"/>	Bowel Urgency	<input type="checkbox"/>		
Headaches	<input type="checkbox"/>	Bowel Incontinence	<input type="checkbox"/>		
Epilepsy or Seizure	<input type="checkbox"/>	Peripheral Neuropathy	<input type="checkbox"/>		
Dizziness/Fainting	<input type="checkbox"/>	Tingling in Arms/Hands	<input type="checkbox"/>		
Falls (last fall date)	<input type="checkbox"/>	Hearing Problems	<input type="checkbox"/>		

WHITE SANDS PHYSICAL THERAPY & AQUATICS

Patient Last Name: _____ First Name: _____ DOB: _____

Do you live alone: Yes No

Living partner disable: Yes No

Height: _____

Weight: _____

SURGERIES: Please list with Date and Details:

OTHER HEALTH ISSUES (Including Chronic Conditions):

Please list: _____

ALLERGIES:

Please list: _____

I have listed all my medical conditions to the best of my knowledge.

I attest that the information provided by me on this medical history form is correct.

Patient Signature

Date

Staff Initials: _____

WHITE SANDS PHYSICAL THERAPY & AQUATICS

MEDICATIONS LIST

Patient Last Name: _____ First Name: _____ DOB: _____

Please provide us with a list of your medications for our files.

	Medication / Vitamin /Supplements	What is it used for	Strength	How Many Times a Day?
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				

Check if apply,

- I am currently not using any medications.
- Please see my list of medications provided on separate page.

I verify that the above list of medications is correct and contains all medications that I am currently taking.

Patient Signature

Date

Staff Initials: _____

WHITE SANDS PHYSICAL THERAPY & AQUATICS

PATIENT DEMOGRAPHICS

PATIENT INFORMATION (Please Print)

Patient Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ Gender: Male Female E-mail: _____

Home Phone: _____ Cell Phone: _____ Social Security #: _____

Address: _____ City: _____ State: _____ Zip: _____

Patient Employer: _____ Work Phone: _____

Out of State Address & Phone #: _____

EMERGENCY CONTACT

Name: _____ Home/Cell Phone: _____

Relationship: _____

INSURANCE:

Medicare #: _____ Part B Effective Date: _____

Is Medicare your primary insurance Yes No If No, which insurance is primary? _____

Insurance Name: _____ Ins ID #: _____ Ins Group #: _____

RESPONSIBLE PARTY INFORMATION (Parent/Guardian if patient is a minor)

Name: _____ Home or Cell Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Gender: Male Female

Authorization to discuss your care with Family or Friends

White Sands Physical Therapy & Aquatics is authorized to discuss health, appointment and/or billing information pertaining to the above patient to the entities below

- Leave information on voice mail: Home Cell Work
- Share information to _____ Relationship: _____
- Share information to: _____ Relationship: _____

White Sands Physical Therapy will bill your insurance as a courtesy to you; however, if no payment is received from your insurance within 45 days of billing, payment in full will be expected from you.

I hereby authorize my benefits, including Medicare, to be paid directly to White Sands Physical Therapy and also authorize the release of medical information necessary to process claims.

Patient Signature

Date

Staff Initials:

WHITE SANDS PHYSICAL THERAPY & AQUATICS

Patient Last Name: _____ First Name: _____ DOB: _____

PHYSICIAN

Date of Next Appointment with Referring Physician: _____

Have you received any physical or speech therapy in this calendar year? Yes No

How many visits: _____ Place of service: _____ Date of last visit: _____

What area(s) of the body was treated? _____

Have you had medical care in your home in the past 60 days? Yes No

How many visits: _____ If yes, please give date(s): _____

Agency that provided care: _____

Medicare will not pay Outpatient Physical Therapy if patient is receiving any type of Home Health Care. This includes Home Health Nursing, Home Health Respiratory, Home Health Aid, and/or any other type of Home Health Care. It is the patient's responsibility to inform the Therapist or office staff if the patient is currently under Home Health Care.

If WSPTA is denied payment because of Home Care Services, then the patient is responsible for the full cost of care provided by WSPTA.

Patients Initials: _____

ACCIDENT:

Are your symptoms related to an accident? Yes No Auto Accident? Yes No

Accident Date: _____ Claim No.: _____

Is the Case Settled? Yes No

Adjuster Name: _____ Phone No.: _____

Attorney: _____ Phone No.: _____

*** Patient that are scheduled to go in the pool, please be aware, NO OPEN WOUND IN THE WATER. If you are to have a biopsy done you will not be able to go into the pool for two weeks after having a biopsy and a written release from your MD will be required to resume pool treatment. We request that for you benefit, all biopsies be scheduled after you have completed therapy (unless otherwise noted by your doctor).**

Patients Initials: _____

*** WSPTA strive to provide the best therapy in the area, any changes in your health while enrolled in our program makes a difference in your care. Please report any falls or injury immediately, your therapies will need to evaluate your condition to make sure that is safe to continue treatment. In the case of a serous injury or fall, a Doctor's note may be required to resume treatment.**

Patients Initials: _____

I attest that the information provided by me on this patient information form is correct.

Patient Signature

Date

Staff Initials:

WHITE SANDS PHYSICAL THERAPY & AQUATICS

Patient Last Name: _____ First Name: _____ DOB: _____

Acknowledge of Receipt of Notice of Privacy Practices

I have received or have been offered a copy of the Notice of Privacy Practices from White Sands Physical Therapy & Aquatics.

Patient Signature

Date

Authorization for treatment, Acknowledgement of Financial Responsibility and Assignment of Benefits

I acknowledge that I am legally responsible for all charges in connection with the medical care, treatment and therapy provided by representatives and personnel of White Sand Physical Therapy & Aquatics, LLC. I consent to the release of any medical information, including diagnosis and the records of any treatment or examination rendered to me for such services to third party payers, health care practitioners and/or managed care organizations. I hereby assign, authorize and direct payment of my medical benefits to White Sands Physical Therapy & Aquatics, LLC. I understand that White Sands Physical Therapy & Aquatics, LLC will assist me in submitting my claims to my insurance carrier. I understand my insurance carrier may not approve or reimburse my medical services in full due to benefit exclusions, coverage limits, lack of authorization, or medical necessity. I understand I am responsible for fees not paid in full, co-payments, policy deductibles and co-insurance except where my liability is limited by contract or State or Federal law. Furthermore, any information given to us may be used for the collection of payments for services provided.

Patient Signature

Date

NO SHOW AND CANCELLATION POLICY

An appointment with a White Sands Physical Therapy and Aquatics therapist reserves a period of time just for you. A cancelled appointment or a no show keeps others from having access to that therapist.

- ❖ We require at least 24 hours' notice of cancellation in advance of your scheduled appointment.
- ❖ All no shows and late cancellations for appointments will be charged \$25.00 for any missed appointment (that includes any portion of your treatment cancelled at the last minute).
- ❖ Please cross check your White Sands schedule against your calendar at home for any conflict that would result in a cancellation fee.
- ❖ This fee must be paid prior to receiving future services.
- ❖ Chronic Cancellations will cause to cancel all patients schedule.
- ❖ Medical insurance can not be billed for missed appointments.
- ❖ I understand that I must call to cancel my appointment 24 hours prior to my scheduled appointment time. **There will be a \$25.00 No call/No show fee assessed when notification is not given for a missed appointment without 24 hours' notice.**

I have read, understand and agree with the provision of this cancellation policy.

Patient Signature

Date

Staff Initials: _____