DME & ASSOCIATES dba Aberdeen Physical Therapy & Fitness

Patient Information

Patient Name_____________________________________ Date Of Birth: ________________

Phone: ____________________ W: _____________________Cell: ____________________

Address: ____

City/ State/ ZIP: ____

Alternate address:____
Employer: ____ Phone: ___________________

Social Security#_______________________________ Marital Status: ____________________

Emergency Contact: ____________________________ Phone__________________

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FINANCIAL POLICY/ AUTHORIZATION AND CONSENT FOR TREATMENT

Most misunderstandings regarding insurance coverage and payments can be avoided if you are aware of the type of insurance coverage you have. If you do not know what kind of coverage you have please check with your insurance company.
Benefits received from your insurance carrier are not a guarantee of payment. If after 90 days, your insurance company does not make payment, and we have sent all pertinent information needed, we will bill you and you will be responsible for collecting payment from your insurance company.
I authorize the release of any medical information necessary to process my claims with my insurance company. I authorize my insurance company to pay bills in connection with these claims directly to Aberdeen Physical Therapy & Fitness. I understand that I will be responsible for any charges that are not covered by my insurance company as well as my co-payment and deductibles at the time of service.

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Signature (patient or parent/ guardian) Date

I acknowledge that I have seen the “Notice Of Privacy Practices”. I understand that I may ask questions about the “Notice Of Privacy Practices” at any time. I hereby consent the use and disclosure of my health information for purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

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Signature (patient or parent/ guardian) Date

DME & Associates, dba Aberdeen Physical Therapy & Fitness

Medical History & Physical Condition

Name: ____ Date: ___________________
Chief Complaint: ___________________________________
Have you had surgery for this injury? _________________ If so When? ______________

Do you now have or have you ever had any of the following?

Asthma, Bronchitis or Emphysema	Yes	No	Arthritis	Yes	No
Shortness of breath/ chest pain	Yes	No	Dizziness	Yes	No
Coronary Heart Disease/ Angina	Yes	No	Heart Attack	Yes	No
Do you have a pacemaker	Yes	No	Seizures	Yes	No
High blood pressure	Yes	No	Stroke/ TIA	Yes	No
Sensitive to Ice or Heat	Yes	No	Blood Clot	Yes	No
Kidney Problems	Yes	No	Hernia	Yes	No
Emotional Problems	Yes	No	Diabetes	Yes	No
Hearing Problems	Yes	No	Cancer	Yes	No
Vision Problems	Yes	No	Allergies	Yes	No
Bladder Problems	Yes	No	HIV/AIDS	Yes	No
Severe Headaches	Yes	No	Numbness	Yes	No
Any pins/ Metal implants	Yes	No	Pregnant	Yes	No
Communicable Diseases	Yes	No	Weakness	Yes	No

Have you had treatment for this/ these problems before? Yes No
If yes, where and when were you treated? ____

List surgical history: ____

List of medications you are currently taking: ____
____

* Is this injury due to workers compensation injury………. Yes______ No ______
* Have you received physical therapy this calendar year……Yes ______ No______
* Are you currently receiving home health services…………Yes ______ No ______

Please check any of the following activities of daily living that are affected by your symptoms

- ☐ Prolonged sitting
- ☐ Getting in/out of car
- ☐ Arising from a chair
- ☐ Gardening
- ☐ Driving
- ☐ Grasping/griping
- ☐ Running
- ☐ Sports participation
- ☐ Occupational demands
- ☐ Dressing/grooming
- ☐ Going up/down stairs
- ☐ Squatting/kneeling
- ☐ Walking
- ☐ Sneezing/coughing
- ☐ Lifting/carrying
- ☐ Housework
- ☐ Reaching Overhead
- ☐ Sleeping
- ☐ Bending: Forward/ Back/ Left/ Right *(circle all that apply)*
- ☐ Lying down: Back/Stomach/Left/Right *(circle all that apply)*
- ☐ Turning/twisting: Left/ Right *(circle all that apply)*

I authorize Aberdeen Physical Therapy to evaluate and treat my conditions. I will be given sufficient opportunity to discuss my condition and treatment with the therapist and all of my questions will be answered before any treatment is to begin. I hereby acknowledge and approve all the information stated in this form to be true and correct.

____
Signature (Patient or parent/guardian) Date

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NO SHOW / CANCELLATION POLICY

Our Staff here at Aberdeen Physical Therapy take your health very seriously. Your physician has recommended physical therapy to improve your daily life. We will make every effort to help you obtain your goals.

Physical Therapy improves your daily life through treatments that have been proven successful. Your physician has determined the frequency of your treatments. A vital component of your success in therapy is your commitment to consistent attendance of your scheduled visits. Frequent cancellations are very detrimental to the outcome of your treatment.

We make every effort to schedule appointments in a way that maximizes your time spent with the therapist. If you are late, it creates a disruption for not just you, also the therapist and all of the other patients. We expect you to keep your appointments and write down the time of your visits so you do not forget.

We understand that serious emergencies may cause you to cancel an appointment. If you need to reschedule an appointment, we require a 24 hours notice. Please call our office to reschedule that visit, which should be made up that same week, preferably the next day.

We reserve the right to charge you a $20.00 fee in an instance of cancellation without a 24-hour notice or for not showing to a scheduled appointment. We also reserve the right to discontinue care and inform your physician if repeated non-compliance with your scheduled visits occurs. (Attention worker's compensation clients: your insurance company will not reimburse for cancelled and missed appointments. So you will be personally held responsible for these fees.)

Understand this policy is intended to maintain the highest quality for care that you receive from our clinic. We thank you for your compliance and we look forward to helping you obtain outstanding results.

I have read and understand the cancellation/ no show policy as described above and agree to make every effort to maintain my therapy schedule to maximize the benefits of physical therapy.

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Patient Signature/ (parent or guardian if under 18) Date