SPINE & REHAB SPECIALISTS
PATIENT INFORMATION

(PLEASE FILL OUT CLEARLY)

LAST NAME	FIRST NAME	MIDDLE INITIAL	
HOME ADDRESS	CITY	STATE	ZIP CODE
HOME PHONE ( ) -	WORK PHONE ( ) -	CELL PHONE ( ) -	
E-MAIL ADDRESS		DATE OF BIRTH / /	
SOCIAL SECURITY# - -	DRIVERS LIC. #	SEX: ☐ M ■ F	Marital status: ☐ S ☐ M ☐ D ☐ W
EMPLOYER		OCCUPATION	
EMPLOYER ADDRESS	CITY	STATE	ZIP CODE
EMERGENCY CONTACT	RELATIONSHIP	PHONE# ( ) -	
HOW WOULD YOU LIKE TO RECEIVE YOUR APPOINTMENT REMINDERS? ☐ PHONE CALL ☐ TEXT ☐ EMAIL			
WHICH PHONE NUMBER/EMAIL SHOULD WE SEND IT TO? _____			

WHO RECOMMENDED US TO YOU		MAY WE THANK THEM FOR REFFERING YOU TO US ☐ Y ☐ N
REFERRING PHYSICIAN	DATE OF PRESCRIPTION / /	FREQUENCY/DURATION
DIAGNOSIS/CHIEF COMPLAINT		
NEXT DR.'S APPOINTMENT:		PRIOR PHYSICAL THERAPY FOR THIS INJURY ☐ YES NO ☐
IS INJURY RELATED TO ☐ WORK ☐ AUTO ACCIDENT ☐ N/A IF YES: DATE / /		WHERE
ACCIDENT DETAILS		

INSURANCE INFORMATION: (please fill out clearly or provide insurance card)

PRIMARY INSURANCE		PHONE # ( ) -	INSURANCE GROUP #
CLAIM / ID #	NAME OF INSURED		RELATIONSHIP TO PATIENT
INSURED DATE OF BIRTH / /	INSURED SS# - -		INSURED EMPLOYER
ADJUSTOR			

SECONDARY INSURANCE		PHONE # ( ) -	INSURANCE GROUP #
CLAIM / ID #	NAME OF INSURED		RELATIONSHIP TO PATIENT
INSURED DATE OF BIRTH / /	INSURED SS# - -		INSURED EMPLOYER
ADJUSTOR			

MVA / AUTOMOBILE ACCIDENT

☐ USE MY HEALTH INSURANCE ☐ YES ☐ NO (If yes, see health insurance above)			
☐ USE PIP (own car insurance) ☐ YES ☐ NO		USE AUTOMOBILE INSURANCE ☐ YES	☐ NO
☐ USE AUTOMOBILE INSURANCE: COMPANY NAME			
POLICY #	NAME ON POLICY		
NAME OF ADJUSTOR	TELEPHONE ( ) -		
☐ VIA ATTORNEY NAME	TELEPHONE ( ) -	(Need Letter of Protection from Attorney)	

MEDICARE PATIENTS ONLY:

Are you currently in home health care for any reason, (or have in the last 3 months)? ☐ Yes ☐ No		
If yes, provide the name of agency	**Dates of treatment:**	**Discharge date: / /**

Please remember that insurance is considered a method of reimbursing the patient for services rendered and not a substitute for payment for services. I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered.

I hereby assign all insurance benefits to which I am entitled to Physiotherapy of El Paso, P.C., d/b/a Spine & Rehab Specialists, including Government (Medicare, Medicaid, Blue Cross Blue Shield and Worker's Compensation) and Private Insurance Companies. This assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is considered as valid as the original. My signature below authorizes release of all information by Physiotherapy of El Paso, P.C, d/b/a Spine & Rehab Specialists, including but not limited to medical, personal, and financial.

If this is a worker's compensation claim, by signing below, I authorize Spine & Rehab Specialists to contact my employer for the purpose of obtaining job description and/or a list of essential job functions to further assist in my rehabilitation process.

I hereby consent to hold harmless any treatment deemed necessary by the Physician, Physical Therapist or designated staff.

Authorized Signature:	**Date:**

SPINE & REHAB SPECIALISTS
FINANCIAL POLICIES

BASIC POLICY: Payment for service and supplies are due in full at the time of service, unless arrangements have been made.

FOR PATIENTS WITH INSURANCE: As a convenience to our patients, we bill most insurance carriers for you. We will also bill most secondary insurance companies for you. Co-payments, co-insurance and/or deductibles are due at the time of service. If an insurance carrier has not paid Spine & Rehab Specialists within 90 days of billing, payment will be due in full from you and Spine & Rehab Specialists has the right to bill you directly for the full amount.

MEDICARE PATIENTS: We will bill Medicare for you. We will also bill secondary insurances for you. All deductibles and/or co-payments are due and payable at the time service is provided.

MEDICAID PATIENTS: All Medicaid patients must provide a current valid card prior to visit. Patient is also responsible for informing us of any changes in Medicaid plans. **A current valid card must be presented at the beginning of every month before services will continue to be rendered.**

MISSED APPOINTMENTS: In fairness to other patients and Spine & Rehab Specialists, a 24 hour notice to cancel appointments is required. **If 3 appointments are missed without any form of cancellation, will result in automatic discharge from physical therapy and the physician will be notified of noncompliance.**

MEDICAL RECORDS: If you need your medical records, please ask for our Medical Records Request Form, and understand we have 15 days to fulfill this request and there will be a $ 25.00 Medical Records Fee.

Please initial that you have read and understand our financial policies: _____.

SPINE & REHAB SPECIALISTS FINANCIAL POLICIES

Acknowledgement of Receipt of Notice of Privacy Practices
(Copy available upon request)

I, _____ , have received the Notice of Privacy Practices from Spine & Rehab Specialists.
SIGNATURE: DATE: / /

In lieu of patient signature, I , _____ , a staff member of Spine & Rehab Specialists, state that
the patient, _____ has been given Notice of Privacy Practices of Spine & Rehab Specialists.
SIGNATURE: DATE: / /

MEDICAL HISTORY FORM

To ensure you receive a complete and thorough evaluation, please provide us with important background information.
If you do not understand a question leave it blank and your therapist will assist you.

Name:	**Date of Birth:**
Height: **Weight:**	

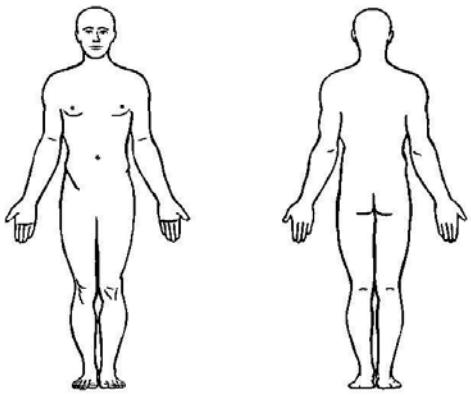
Occupational/Leisure Activities:			
Restrictions:			
ARE YOU CURRENTLY UNDER THE CARE OF:	**YES**	**NO**	**IF SEEN IN LAST 3 MONTHS, PLEASE EXPLAIN**
Medical Doctor/Osteopath			
Dentist			
Chiropractor			
Psychiatrist/Psychologist			
Physical Therapist			
Other (explain)			

HAVE YOU HAD ANY RECENT DIAGNOSTIC TESTS?	**YES**	**NO**	**DATE**	**RESULTS**
X-rays				
MRI				
CT Scan				
EMG				
Other (explain)				

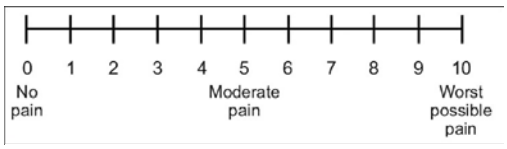
PLEASE ANSWER THE FOLLOWING:	**YES**	**NO**	
Have you had any therapy in the last 12 months?			**Where?**
Are you pregnant?			**Due date:**
Do you smoke?			**How often?**
In the past month, have you noticed a change in bowel & bladder activities?			
During the past month, have you often been bothered by feeling down, depressed, or hopeless?			
During the past month, have you often had little interest or pleasure in doing things?			
Do you want help with that?			**Yes, but not now**

Condition/Disease	**Never**	**Now**	**Past**
Heart Disease			
Lung Disease			
Seizures / Epilepsy			
Pacemaker			
High / Low Blood Pressure			
Diabetes			
Stroke / T.I.A.			
Cancer			
Asthma			
Osteoporosis			
Back Injury			
Fracture			
Rheumatoid Arthritis			
Osteoarthritis			
Headaches			
Dizzy Spells			
Fainting Spells			
Unexplained Weight Loss			
Falls / Loss of Balance			
Latex Allergy			
Infections			
HIV/AIDS			
Blood Clots			

Please indicate on the body chart where you are having pain?



Please rate your current pain level:



List any medications you are taking:

Please list any surgeries you have had and when:
Please list any other conditions/diseases we should know about:

Signature of patient or legal guardian: **Date:**