MARKETPLACE
PHYSICAL THERAPY
& WELLNESS CENTER

CONFIDENTIAL PATIENT HISTORY

Please complete this questionnaire. This confidential history will be part of your permanent records.
THANK YOU

Full Name _____ **Date of Birth** ___ /___ /____ **Sex:** ❑**M** ❑**F**

Address: _____ **City** _____ **State** ____ **Zip** _____

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

Soc. Sec. # _____ **Is the patient a dependent** ❑**Yes** ❑ **No**

*Please provide your email address in order to have direct communication with your Physical Therapist and digital access to your Home Exercises through StriveHub.

Email Address: _____

Emergency Contact Name _____ **Phone #** _____

Work Comp Adjuster Name _____ **Phone #** _____

Occupation _____

How did you hear about us? ❑ Medical Doctor ❑ Google ❑ Yelp ❑ Friend/Family

❑ Other _____

Date of Injury: _____

What is your major complaint? _____

List ALL surgical operations and years: _____

_____

Do you have a primary doctor? ❑**Yes** ❑**No** **If Yes, Name:** _____

Medications, dosage and frequency: _____

_____

Privacy Policy Statement
Marketplace Physical Therapy conforms to all HIPAA (Health Insurance Portability and Accountability Act) privacy regulations. Patients' information will only be used for authorization of treatment and reimbursement for services provided.

Signature of Patient/Parent or Legal Guardian_____***Date*** _____

MEDICAL HISTORY

Cancer	❑Yes ❑ No	Kidney Problems	❑Yes ❑ No
High Blood Pressure	❑Yes ❑ No	Liver Problems	❑Yes ❑ No
Pacemaker	❑Yes ❑ No	Claustrophobia	❑Yes ❑ No
Cardiac Condition	❑Yes ❑ No	Nervous Disorders	❑Yes ❑ No
Are you Pregnant?	❑Yes ❑ No	Unexplained Coughing	❑Yes ❑ No
Heart Attack	❑Yes ❑ No	Respiratory Illness	❑Yes ❑ No
Circulation Problems	❑Yes ❑ No	Arthritis	❑Yes ❑ No
Seizures	❑Yes ❑ No	Sensitivity to Heat	❑Yes ❑ No
Dizzy Spells	❑Yes ❑ No	Sensitivity to Cold	❑Yes ❑ No
Diabetes	❑Yes ❑ No	Speech Problems	❑Yes ❑ No
Fractures	❑Yes ❑ No	Vision Problems	❑Yes ❑ No
Stroke	❑Yes ❑ No	Metal Implants	❑Yes ❑ No

Are you currently experiencing, or have experienced recently:

Fever	❑Yes ❑ No	Night Sweats	❑Yes ❑ No
Coughing	❑Yes ❑ No	Coughing up blood	❑Yes ❑ No
Unexplained Rash	❑Yes ❑ No	Stiff Neck	❑Yes ❑ No
Unexplained Weight Loss	❑Yes ❑ No	Painful, Swollen Salivary Glands	❑Yes ❑ No
Chronic Fatigue	❑Yes ❑ No		

Have you been exposed to any of the following illnesses?

Chicken Pox	❑Yes ❑ No
Meningitis	❑Yes ❑ No
Shingles	❑Yes ❑ No

WEIGHT: _____ HEIGHT: _____

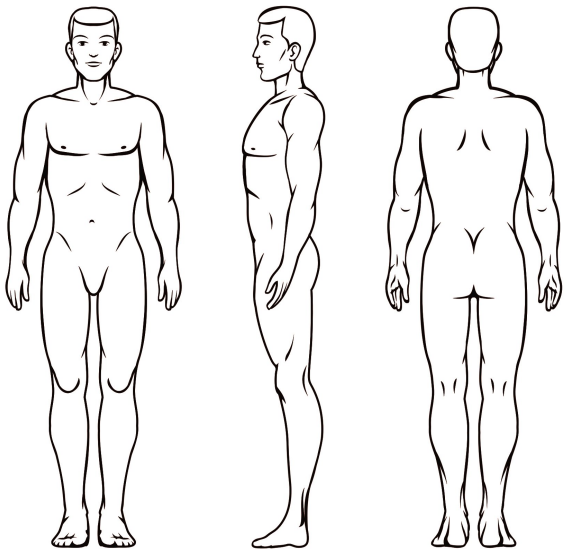
PLEASE CIRCLE: 1 being no pain 10 being severe pain

Pain level at worst: 1 2 3 4 5 6 7 8 9 10

Pain level currently: 1 2 3 4 5 6 7 8 9 10

Pain level at best: 1 2 3 4 5 6 7 8 9 10

MARK THE AREAS OF YOUR SYMPTOMS ON THE FIGURES BELOW



***Signature of Patient/Parent or Legal Guardian*_____*Date* _____**

FINANCIAL AGREEMENT

We have found over the years that paying as you go is the best possible solution for everyone involved. This will save you the hassle of a large bill at the end of your treatment. Keep in mind that even after paying your "estimated" amount each visit, there may be a balance due at the end of treatment, but if so, it is usually substantially less than what you would have received if you did not pay on your account as you go.

Insurance Coverage:

- **Marketplace Physical Therapy verifies your insurance coverage as a courtesy to you, and is not a guarantee of coverage. If the information provided by your insurance company is not accurate or the coverage changes, you will be responsible for payment on all services not paid.**

Patient Financial Responsibility:

- Patient is responsible for a co-payment of $ _____ for each visit.
- For cash patients, sessions are to be paid in full before each treatment.

Cancellation Policy:

- If you fail to show up to your appointment without notice and do not cancel ***within 24 hours*** you will be assessed a **$20 fee** that will be billed to you (***not your insurance***).
- If you show up past your scheduled appointment time, we will do our best to accommodate and treat you that day. However, if you are **late by 15 minutes or more** we will have to reschedule your appointment due to time constraints.

Financial Agreement:

I understand that insurance claim forms will be submitted to my insurance company as a matter of **convenience only**, and that I am primarily responsible for all charges regardless of my existing medical coverage.

- I hereby give authorization for payment of insurance benefits to be made directly to Marketplace Physical Therapy for services rendered.
- I understand that I am financially responsible for all charges not paid by my insurance company. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees.
- I hereby authorize this health care provider to release all information necessary to secure the payment of benefits.
- I further agree that a photocopy of the agreement is as valid as the original. (Workers Comp Patients - Lines 2 and 3 of this paragraph do not apply)

I request that my records, diagnosis, and any other information needed concerning my accident/injury/illness, be released to Marketplace Physical Therapy, its representatives and the treating physician for reporting purposes.

I have read all of the above information and understand that I am financially responsible for all services rendered and that Marketplace Physical Therapy is billing my insurance company as a courtesy to me. In the event that my insurance company is not paying my claims, I will participate in helping Marketplace Physical Therapy get these claims paid.

Authorization for Treatment
I hereby consent to and authorize all therapy treatments, which in conjunction with the judgments of the attending physician may be considered necessary or advisable for the diagnosis or treatment for the above named patient at Marketplace Physical Therapy

Signature of Patient/Parent or Legal Guardian _____ ***Date*** _____