New Patient Information Sheet

Please help us make the best use of our time together by completing this prior to your appointment.

Name:							Today's date:				
ivallie.	Last Name			First Name			Today's date.				
Address:											
City / State / ZIP:											
Phone #	MOBILE				HOME				WORK		
DOB://						Age:					
Email:											
Occupation:				Employ	mployer:						
Emergency Contact		Name:	e:			Phone:	Phone:				
Primary Care Physician		Name:									
Specialist Physician		Name:									
How did you hear about our practice?											
Who can we thank for referring you to our practice			ractice ^e	?							
Please fill out these forms as specifically as possible to provide us with a clear picture of your											

Please fill out these forms as specifically as possible to provide us with a clear picture of your present pain and functional status.

What is the primary issue/problem that brings you in today?	Please shade in areas where you have
Secondary concern/problem?	pain, discomfort, or tension.
As a result, I am now having difficulty with:	
Are you currently experiencing pain as a result of these symptoms? If yes, what is it like?	Two was the way
When did your symptom(s) begin? (Date):	and the second s

	At its worst	
Please rate your pain in the last 24-72 hours	At its best	
Using the "0 -10" scale where 0 is no pain and 10 is the worst possible pain.	At present	
	Night (sleeping)	

P	At what time of	day a	are your sy	mptom	s the wors	t?					
Α	At what time of	day a	are your sy	mptom	s the best	?					
۷	What activities	increa	ase your pa	ain?							
۷	Vhat activities	decre	ase your p	ain?							
		What	, , , , , , , , , , , , , , , , , , ,	es of t	Physical	have y	ou had fo				
	Massage		Bodywork		Therapy		Release		Chiropractic		Surgery
e	r Medical Treatmen	it: (Pleas	se Describe)								
	Che	ck the	box if yo	u have	had any	of the	following	medica	l conditior	าร?	
	Diabetes		Lung diseas	se	Weight change		Varicose ve		Neurological problems		Pregnancy
	Rheumatic fever		Osteoporos	sis	Migraine headache		Epilepsy seizures	;	Stroke		Blackouts
_	Heart Murmur		Malignanc	у	Arthritis		Broken bones (fracture		Metal implants		High blood pressure
	Circulatory Liver disease Heart disease / pacemaker			Kidney disease		Others (explain below)		n below)			
_											
L	ist past medic	al hist	tory and da	ates of	occurrence	e. Inclu	ide surgeri	es, acci	dents and o	ther t	raumas.
	ist ALL medica their	ations	which you iveness. (are cu Include	rrently taki suppleme	ng, the	condition (for whic	h you are u	sing t	hem and
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Task / Activity	Tolerance (minutes/hours)

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Patient Goals Please list the activities that you would like to be able to do as a result of therapy.

Task / Activity	Duration / How Often	By When
Other Goals?		

INFORMED CONSENT

I understand that Full Reps Physical Therapy will maintain my privacy to the highest standards and may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment.

Photographs taken during initial evaluation, progress evaluation and discharge summary will be used for postural comparison purposes and as educational tools. By signing below, I consent to the use of these photographs in a professional manner.

I do hereby agree and give my consent for Full Reps Physical Therapy to furnish care and treatment that is considered necessary and proper in the diagnosing or treating of my physical condition. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time. I hereby certify that all the above information is true to the best of my knowledge.

FINANCIAL POLICY

Bob Gorinski, PT is not a preferred provider for insurance companies. Instead, Full Reps Physical Therapy, LLC is a cash-based practice. By not having a preferred

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provider/contracted status with the insurance companies, the therapist does not have to limit the time or quality of treatment provided secondary to insurance restrictions or elevate clinic rates for billing and collections services.

Prior to your first scheduled appointment, call your insurance company to completely understand your physical therapy benefits. You may complete the Insurance Benefits Worksheet (on the website at FullRepsTraining.com) to help you ask the insurance company the right questions about your physical therapy benefits. At the time of service and payment, you will receive a written statement which you can submit to your insurance company for their consideration of reimbursement to you.

Full Reps Physical Therapy will be happy to provide you chart notes or other documentation at your (or your insurance company's) request. The amount of reimbursement that you will receive will vary with the terms of your insurance policy. Some companies may reimburse you at 80%, some at 60%, some at 40%, and some may not reimburse you at all. Full Reps Physical Therapy cannot make guarantees or estimates regarding what reimbursement your plan allows.

Rates are based on time spent with you and the treatments performed during your appointment. The rates are as follows:

\$ 85.00 for Initial Evaluation \$ 65.00 for 60-minute follow-up \$35 for 30-minute follow-up

CANCELLATION/NO SHOW POLICY - We are entering into a cooperative partnership to help you attain your maximal physical therapy goals. It is understandable that circumstances may arise which cause you to cancel your appointment. However, cancellations have a serious impact on the clinic. Cancellations more than 24 hours in advance will not be charged. Cancellations less than 24 hours will be charged the full price of the service scheduled.

By signing this document, I a	agree to these conditions:	
Patient Signature	Date	
Print Name		
Patient/Parent/Guardia	n Signature:	
	Date:	