



New Paradigm

physical therapy

Patient Data Sheet

Please complete this form in its entirety prior to your first visit. Also, please bring your insurance information and/or cards to our office at your first visit. **It is the patient's responsibility to notify our office of any changes to your information listed on this form.**

PATIENT INFORMATION

Name: _____
LAST FIRST MIDDLE

Address: _____
STREET CITY STATE ZIP

Home# _____ Work# _____ Cell# _____

Email: _____ Preferred contact method: HOME WORK CELL Sex: MALE FEMALE

Date Of Birth: _____ MARRIED SINGLE WIDOWED SEPARATED OTHER

Referring Physician: _____ Primary Care Physician: _____

Employer Name/Address: _____
NAME STREET CITY, STATE, ZIP

Emergency Contact: _____ Phone: _____
NAME/RELATION

The above information pertains to the patient only. If the patient is a minor, then the responsible party completes the next section.
If the patient is not a minor, then skip the next section.

RESPONSIBLE PARTY INFORMATION - Relation to patient: MOTHER FATHER OTHER

Name: _____
LAST FIRST MIDDLE

Address: _____
STREET CITY STATE ZIP

Home# _____ Work# _____ Cell# _____

Employer Name/Address: _____
NAME STREET CITY, STATE, ZIP

Date Of Birth: _____

INSURANCE INFORMATION: Are you aware of your benefits for your insurance? NO YES

Primary Insurance Name: _____ Insured Name: _____

Primary Insurance Address: _____ Phone: _____

Policy ID# _____ Policy Group# _____ See Copy Of Card

Secondary Insurance Name: _____ Insured Name: _____

Secondary Insurance Address: _____ Phone: _____

Policy ID# _____ Policy Group# _____ See Copy Of Card

ACCIDENT INFORMATION: Was this injury the result of an accident? NO YES Date Of Accident/Injury: _____

Motor Vehicle Accident Work Related Other

CONSENT: By signing this form, I agree and give my consent for New Paradigm Physical Therapy, LLC to furnish physical therapy care and treatment considered necessary and proper in diagnosing and/or treating my physical condition(s).

Internet users: When document is completed, please re-save/print and bring in to your next appointment.

Signature _____ Date _____



General Medical History

Please complete this form in its entirety prior to your first visit. Also, please bring your insurance information and/or cards to our office at your first visit. It is the patient's responsibility to notify our office of any changes to your information listed on this form.

PATIENT INFORMATION CONTINUED

At the present time, how would you rate your overall general fitness: [] Excellent [] Good [] Fair [] Poor

Please check all conditions that you have, or have had in the past

Musculoskeletal

- [] Osteoarthritis
[] Rheumatoid Arthritis
[] Lupus / SLE
[] Fibromyalgia
[] Osteoporosis
[] Bulging Disc
[] Leg Cramps/Restless Legs
[] Jaw Pain / TMJ
[] Implanted devices
[] Use of cane or walker
[] Gout
Other: _____

Psychological

- [] Depression
[] Anxiety
[] Bipolar disorder
[] Schizophrenia
Other: _____

Skin

- [] Skin allergies
[] Eczema
[] Rashes
[] Psoriasis
Other: _____

Cancer

Type of Cancer: _____

Date of Diagnosis: _____ Treatments: _____

Please list all current prescription medications that you are taking for any condition: _____

Please list all prior surgeries: _____

Please list all allergies: _____

Are you currently pregnant? [] NO [] YES Do you currently smoke? [] NO [] YES

Anything else you would like me to know: _____

Nervous System

- [] Stroke / TIA
[] Polio
[] Parkinson's disease
[] Multiple Sclerosis
[] Epilepsy / Seizures
[] Headaches / Migraines
[] Concussion / TBI
[] Numbness or Tingling
Other: _____

Urinary

- [] Kidney Dysfunction
[] Bladder Dysfunction
Other: _____

Cardiovascular

- [] Heart Attack
[] Heart Surgery
[] Heart Arrhythmia
[] Pacemaker
[] High Cholesterol
[] Blood Clots / Phlebitis
[] Anemia
[] High Blood Pressure
[] Asthma / SOB
[] COPD
Other: _____

Infectious Disease

- [] TB
[] Hepatitis
[] Influenza
[] Shingles
[] Night sweats / fevers
Other: _____

Digestion

- [] Irritable Bowel
[] Liver Dysfunction
[] Reflux disease
[] Hernia
Other: _____

Endocrine

- [] Diabetes
[] Thyroid Dysfunction
Other: _____

Patient's Signature



Conditions And Consent For Therapy

Thank you for choosing New Paradigm Physical Therapy for your physical therapy needs. This office is committed to providing the highest quality physical therapy care.

1. Cooperation With Treatment

I understand that in order for physical therapy services to be effective I must come as scheduled unless there are unusual circumstances that prevent me from attending therapy.

I understand that I may be discharged from therapy if I do not keep three (3) appointments without calling to cancel to reschedule and that there is a fee for missed appointments if I do not provide 24 hours notice.

I understand that it is my responsibility to attend my appointments at the scheduled time and that I may be asked to reschedule if I am more than 15 minutes late for my appointment.

I agree to cooperate with the home program assigned to me. If I have difficulty then I will discuss it with my therapist.

2. No Warranty

New Paradigm Physical Therapy (NPPT) does not promise a cure for my condition. The treating therapist will provide you with a prognosis for your condition and discuss treatment options with you.

3. Informed Consent To Treatment

The term "informed consent" means that the potential risks, benefits and alternatives of physical therapy treatment have been explained to you via the narratives found below. NPPT provides a wide scope of services and you will receive information at the initial visit on the treatment/assessment options available for your condition. Treatment may be modified during the course of your care depending on your response to the interventions.

POTENTIAL RISKS

You may experience an increase in your current level of pain or discomfort, or an aggravation of your existing injury. This discomfort is usually temporary and will probably subside within 24 hours.

POTENTIAL BENEFITS

Benefits include an improvement in your symptoms and an increase in your ability to perform your daily activities. You may experience increased strength, awareness, flexibility, and endurance in your movements. You may experience decreased pain and discomfort. You will have greater knowledge on how to manage your condition and the resources available to you.

ALTERNATIVES

If you do not wish to participate in physical therapy at NPPT then you may discuss your medical, surgical, or pharmacological alternatives with your physician.

I have read or had read to me the foregoing and any questions which may have concerned me have been answered to my satisfaction. I understand the risks, benefits, and alternatives to treatment. Based on this information I voluntarily consent to physical therapy treatment. I understand that I may withdraw at any time.

Patient's Signature

Date

Patient's Legal Representative/Guardian/Parent

Relationship to Patient



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Financial Policy And Agreement

Thank you for choosing New Paradigm Physical Therapy for your physical therapy needs. This office is committed to providing the highest quality physical therapy care. To avoid any misunderstanding, the following is an explanation of our Financial Policy and Agreement which we ask you to read and sign prior to any evaluation or treatment.

HEALTH INSURANCE PATIENTS

PRIVATE PAY/NO INSURANCE PATIENTS

1. Patient is responsible for knowing their Physical Therapy Insurance Benefits, including if Pre-Authorization or a PCP Referral is required by their Insurance in order to receive benefits.
2. Your Insurance is a CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY, as a courtesy this office will submit bills to your Health Insurance carrier.
3. After 60 days, there will be a finance charge of 1.75% per month (21% annual) posted to your account.
4. A \$20.00 fee will be charged on all returned checks and missed appointments not cancelled 24 hours in advance.
5. Payments of all insurance co-pays and deductibles are due at the time services are rendered.
6. I will provide all insurance policy information and changes to NPPT. If my insurance information is not supplied within one week, I will pay all charges.
7. I understand that if my insurance benefits are maxed or denied for not medically necessary I will be billed a private pay fee that is due at the time services are rendered.

Patient Signature or Responsible Party

Date

By signing above, I acknowledge receipt of this Financial Policy and Agreement and agree to abide by its terms. I agree to pay any collection costs and/or reasonable attorney's fee if any delinquent balance is referred to an agency or attorney for collection or suit.

AUTO AND WORKERS COMPENSATION PATIENTS

1. I understand that I must furnish NPPT with my No-fault Auto Insurance/Workers Compensation information, within one week of my first visit or personally pay for all incurred charges. Information will include:
 - a. My No-Fault auto Carrier's/Workers compensation Name, Address, Claim #, Adjustor's Name and Telephone Number.
2. Your Auto Insurance/Workers Compensation policy is a CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY as a courtesy this office will submit bills weekly to your Auto Insurance/Workers Compensation carrier. If your Auto Insurance/Workers Compensation has not paid the billed charges in full within 60 days, the outstanding balance MUST BE PAID BY YOU.
3. I understand that when my Auto Insurance PIP (Personal Injury Protection)/Workers Compensation is exhausted I have two options:

Bill my Health Insurance. I understand if this insurance information is not given, I will be personally responsible for full payment of all charges.

Private Pay which I understand is due on the day of my treatment.

A \$20.00 fee will be charged on all returned checks and missed appointments not cancelled 24 hours in advance.

Patient Signature or Responsible Party

Date

By signing above, I acknowledge receipt of this Financial Policy and Agreement and agree to abide by its terms. I agree to pay any collection costs and/or reasonable attorney's fee if any delinquent balance is referred to an agency or attorney for collection or suit.



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Privacy Practices Acknowledgement and Medical Record Release

Please read our Privacy Policy on our website and complete this form in its entirety and bring it with you to your first visit.

PRIVACY PRACTICES

I have received a Notice of Privacy Practices and I have been provided an opportunity to review it.

Name

Date

Signature

ACCESS TO MEDICAL INFORMATION AND RECORDS

New Paradigm Physical Therapy is authorized to release my protected health information to my referring doctor/dental office and additionally to the following people:

Name

Relationship to Patient

Name

Relationship to Patient

- I allow New Paradigm Physical Therapy permission to leave a detailed message about my appointment or procedure on my:

Cell Phone

Home Phone

With (family member of household member)

- I DO NOT want New Paradigm Physical Therapy to leave a message about my appointment or procedures.

Patient Signature or Responsible Party

Date