ILLARI PHYSICAL THERAPY

Patient Name:_____Today's Date:___/___/____

What do you prefer to be called: _____◇Male◇Female

Birthdate:_____/_____/_____Age:_____Social Security Number_____-_____-_____

Address:_____

City:_____State:_____Zip Code:_____

Home Phone #:_____

Work Phone #:_____

Cell Phone #:_____

Email Address:_____

Preferred form of contact: ( ) Home phone ( ) Cell phone ( ) Work Phone ( ) Email

Who should we contact in case of emergency?_____

Relation to you:_____Phone #_____

Employer:_____

Employer's Address:_____

City:_____State:_____Zip Code:_____

Occupation:_____

Status: ◇Minor ◇Single ◇Married ◇Divorced ◇Separated ◇Widowed

Spouse's Name:_____How many children do you have_____

Are you taking any medication? ◇No ◇Yes Please list:_____

_____

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Do you have or have you ever had any of the following:

Y N Heart Attack	**Y N** Heart Surgery	**Y N** Stroke
Y N Pacemaker	**Y N** Heart Murmur	**Y N** Congenital Heart Defect
Y N Alcohol/Drug Abuse	**Y N** HIV+/AIDS	**Y N** Frequent Neck Pain
Y N High Blood Pressure	**Y N** Low Blood Pressure	**Y N** Headaches
Y N Fainting	**Y N** Seizures/Epilepsy	**Y N** Diabetes
Y N Tuberculosis	**Y N** Lower Back Problems	**Y N** Mitral Valve Prolapse
Y N Venereal Disease	**Y N** Shingles	**Y N** Emphysema
Y N Glaucoma	**Y N** Psychiatric Problems	**Y N** Kidney Problems
Y N Sinus Problems	**Y N** Difficulty Breathing	**Y N** Artificial Bones/Joints
Y N Artificial Valves	**Y N** Hepatitis	**Y N** Cancer
Y N Anemia	**Y N** Rheumatic Fever	**Y N** Ulcers/Colitis
Y N Asthma	**Y N** Chemotherapy	**Y N** Arthritis

Other:_____

Please list any allergies:_____

Please list any previous surgeries or serious illnesses with dates:_____

_____

Do you smoke? ◇No ◇Yes **Do you drink alcohol? ◇No ◇Yes**

<u>For Women:</u> Are you taking Birth Control? ◇No ◇Yes

Are you pregnant? ◇No ◇Yes How far along?_____**Are you nursing? ◇No ◇Yes**

What is the reason for your visit?_____

_____

_____

_____

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
- I authorize the staff of Illari Physical Therapy, P.C. to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature_____**Date**_____/_____/_____

HIPAA AWARENESS AGREEMENT

I understand that Illari Physical Therapy, P.C. will release my information:

1. To any requesting health care provider for my further diagnosis, care or for that provider's payment or health care operation purposes
2. To any person or entity which may be responsible for billing/collection of claims for medical services or products
3. To any person or entity which is, or may be liable to Illari Physical Therapy, P.C. for all or part of Illari Physical Therapy, P.C. charges, including but not limited to, insurance companies, HMO or third party payer
4. To any government agency or other organization responsible for oversight of Illari Physical Therapy, P.C. or a third party payer
5. For Illari Physical Therapy, P.C. normal health care operations.

I understand that Illari Physical Therapy, P.C. may communicate information including protected health information with me through print, or email and through Illari Physical Therapy, P.C. electronic health records system.

With my permission, Illari Physical Therapy, P.C. may email or call my home, or other designated locations and leave a message on voice mail or in person, in reference to any items that may assist Illari Physical Therapy, P.C. in carrying out treatment, payment, and healthcare operations, such as appointment reminders, insurance matters, services rendered and/or any information pertaining to billing/collections.

Special requests for confidential communications:

_____

_____

_____

Patient/Guardian Name (Print):_____ **Date:**_____

Patient/Guardian Signature:_____ **Date:**_____