A Step Ahead
Physical Therapy

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

Preferred Name: _____ Gender: ☐Male ☐Female Marital Status: _____

Date of Birth: ____/____/____ Age: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell phone: _____

Email Address: _____

REMINDER METHOD

☐Text (phone provider _____) ☐Email ☐Phone Call

EMERGENCY CONTACT

Name: _____ Phone Number: _____ Relationship to Patient: _____

INSURANCE INFORMATION

Primary Insurance: _____ ID # _____

Secondary Insurance: _____ ID # _____

CASE INFORMATION

What are you being seen for: _____ When did this occur: _____

Referring Physician: _____ Phone Number: _____

Date of Last Appointment: _____ Date of Next Appointment: _____

Primary Care Physician (if different): _____ Phone Number: _____

Was this a Motor Vehicle Accident? ☐ Yes ☐ No If yes, what state did the accident occur in? _____

Is this a Workers Compensation Case? ☐ Yes ☐ No

How did you hear about us? ☐ Doctor ☐ Family/Friend ☐ Internet Search ☐ Insurance Company ☐ Other

Whom may we thank for your referral? _____

Signature: _____ Date: _____

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A Step Ahead Physical Therapy is dedicated to providing the best possible care for you in a warm, comfortable environment. All services are provided by a licensed Physical Therapist.

By signing below, I acknowledge and consent to the following, where applicable:

1. **MEDICAL CONSENT:** I authorize A Step Ahead Physical Therapy to perform physical therapy assessment and treatment (or Wellness sessions) as requested for myself or my family member, which will be discussed with my therapist.
   I have provided full disclosure of any and all relevant past medical history that may impact, influence or contraindicate the services provided by A Step Ahead Physical Therapy.
   I understand that A Step Ahead Physical Therapy is fully licensed, and its providing therapists are highly trained and skilled. They will ensure that the service provided is safe, appropriate, and indicated for my condition.
2. **TELEHEALTH AUTHORIZATION:** A Step Ahead Physical Therapy may be providing my therapy services via telehealth if needed. I understand that my appointments may be virtual taking place with an application discussed by me and my therapist. I understand that A Step Ahead Physical Therapy is not responsible for any injury or damage that my result from the use of the techniques taught or the information provided during a telehealth visit. I understand that I am participating in telehealth physical therapy at my own risk. Telehealth is billed to my insurance or paid for out of pocket in the same manner as a regular physical therapy session. I understand that I am responsible to pay for these services on receipt of the bill.
3. **PAYMENT FOR SERVICES:** I understand that payment is expected at the time of service for all services, and I am fully responsible for all fees that are not covered by my insurance except those prohibited by the insurance carrier if we are in network. Out of network insurance will be billed at full rate and any reductions taken by my insurance company are my responsibility. Insurance will be filed for services rendered as directed by me. Co-pays or co-insurance are expected at the time of service. I also understand it is my responsibility to know my insurance policy and their requirements for reimbursement and that reimbursement is not guaranteed. I will be billed for any portion that my insurance company does not cover if out of network.
4. **MEDICAL INSURANCE BENEFITS:** A Step Ahead Physical Therapy will verify my insurance coverage prior to service and filing claims. Based on this information, A Step Ahead Physical Therapy will estimate the portion of charges for which I should be responsible, taking into consideration coordination of benefits should I have coverage under multiple insurance policies. A Step Ahead Physical Therapy is not responsible for any incorrect information my carrier has relayed to them. There are *no guarantees* to the accuracy of the verification process or any payment amounts received from my insurance company. The final indicator of coverage is the Explanation of Benefits (EOB). I am responsible for any balances not covered by the policy. Disputes regarding benefits are between the patient and insurance company. I will notify A Step Ahead Physical Therapy of any changes in my insurance. If an appeal is needed, I agree to allow A Step Ahead Physical Therapy to file an appeal on my behalf.
5. **MEDICARE AUTHORIZATION:** I certify that the information given in applying for payment under TITLE XVII of the Social Security Act is correct and requests payment of authorized benefits to be made on my behalf. I authorize A Step Ahead Physical Therapy to release to Medicare Bureau, Health Care Financing Administration or its intermediaries or its carriers, any information needed for Medicare claims, including medical information for the purpose of processing

a claim for Medicare benefits. I also authorize the release of medical and related information about my treatment to the utilization and quality control peer review organization responsible for reviewing the medical care furnished. At this time, Dry Needling is a non-covered service under Medicare and therefore we will not bill your insurance. I understand that payment for this service will be expected at the time of service. (Please see subsequent forms for Dry Needling consent, Advanced Beneficiary Notice and payment structure.)

6. **CANCELLATION POLICY:** A Step Ahead Physical Therapy asks that I give **24-hour prior notice for cancelling** or rescheduling appointments as a courtesy to the Therapists and to other patients trying to schedule appointments. Appointments cancelled with less than 24 hours that cannot be rescheduled that same day are considered a "Same Day Cancellation". After reaching three (3) "Same Day Cancellations", all of my scheduled appointments will be removed and I will be placed on the Day to Day list where I will be required to call in day to day to see if there is an appointment available that fits my availability. I will be informed of the times open (if any) for that day/for each therapist. This allows me to have more flexibility with appointments, but I will not be guaranteed the same therapist each visit.
7. **SCHEDULING POLICY:** A Step Ahead Physical Therapy schedules a full hour of therapy for each patient. No other patients are scheduled with that therapist at that time. This ensures I am receiving the best care and getting the most out of my rehabilitation. I may request shorter or longer appointments if deemed appropriate by my therapist.
8. **SELF PAY DISCOUNT:** A discount is available to those who pay in full at the time of service and do not require A Step Ahead Physical Therapy to file claims with health insurance. If I choose for A Step Ahead Physical Therapy not to file claims or take any insurance information, I may file with my health insurance on my own. In this case A Step Ahead Physical Therapy will provide the proper receipts and documentation to be submitted.
9. **MEDICAL RECORDS RELEASE:** I authorize A Step Ahead Physical Therapy to release any medical records (including any information furnished to A Step Ahead Physical Therapy or obtained by A Step Ahead Physical Therapy in connection with my treatment) to any referring physician, insurance company, health care facility, or government agency requesting such information. Authorization is also given to release records to insurance carriers for the purpose of payment of claims including worker's compensation claims to both carrier and employer.
10. **SELF-REFERRED/DIRECT ACCESS:** I understand that a physical therapist diagnosis is not a medical diagnosis by a physician or based on radiological images and that such services might not be covered by my health plan or insurer. Self-Referred/Direct Access allows for treatment for 21 days or **8 visits** from the initiation of a physical therapy plan of intervention. Medicare and Medicare replacement plans require a physician signature on the Plan of Care for any treatment.

    I understand that if I am a self referred patient I am unable to receive dry needling without my Physical Therapist consulting with my Physician.
11. **STUDENT OBSERVATION:** A Step Ahead Physical Therapy has several observation internships with students within our clinic. Students are required to complete a certain number of observation hours before applying to a Physical Therapy Program. In regard to this A Step Ahead Physical Therapy has made me aware of my rights as a patient. I can request not to be observed by a student and different arrangements will be made, including a private room. My comfort is of utmost priority and every step will be taken to ensure that I feel comfortable with my treatment.

I CONSENT TO ALL THE ABOVE AND ACKNOWLEDGE THE RECEIPT OF THE PRIVACY PRACTICE NOTICE AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION: I acknowledge that I have been given a copy of the Notice of Privacy Practices and am providing consent for the use of my protect health information in the manner described in the Notice of Privacy Practices.

Signature: _____ **Today's Date:** _____

*** (If client is under 18 years old, this form should be signed by a parent or guardian.)

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HEALTH HISTORY

Name: _____ Height: _____ Weight: _____ Age: _____ Date: _____

Highest Level of Education: _____ Employment: _____

Rate your health: ☐Excellent ☐Good ☐Fair ☐Poor Have you had any major life changes in the past year?☐Yes ☐No

Average Blood Pressure: _____ Are you: ☐ Right Handed ☐ Left Handed

Do you exercise regularly? ☐ Yes ☐ No If yes, how often and what types? _____

Tobacco use? ☐Never ☐Past ☐Current; If current type/how much?_____

Alcohol use? ☐Never ☐Past ☐Current; If current type/how much?_____

Do you have any customs/religious beliefs/wishes that might affect care? _____

Medical/Surgical History: ☐Arthritis ☐Blood Disorders ☐Broken Bone/Fracture ☐Cancer _____
☐Circulation/Vascular ☐Depression ☐Developmental/Growth Problems ☐Diabetes ☐Eating Disorder
☐Gynecological Problems ☐Head Injury ☐Hearing Problems ☐Heart Conditions or Heart Attack ☐Hepatitis ☐Hernia
☐High Blood Pressure ☐HIV/AIDS ☐Infectious Disease ☐Irregular Menstruation ☐Joint Replacement ☐Kidney Problem
☐Lung problems ☐Memory Problems_____ ☐ Multiple Sclerosis ☐Osteoporosis ☐Parkinson's Disease
☐Prostate Disease ☐Seizures/Epilepsy ☐Stroke ☐Thyroid Problems ☐Ulcers/Stomach Problems ☐Other_____
☐History of COVID-19 /vaccinated ☐Lingering Side Effects from COVID-19 _____

Within the past year, have you had any of the following symptoms? ☐ Abdominal/Pelvic Pain
☐Bowel Problems/Constipation ☐Chest pain ☐Coordination Problems ☐Difficulty Sleeping ☐Difficulty Swallowing
☐Difficulty Walking ☐Dizziness/Fainting ☐ Number of Falls_____ ☐Fatigue ☐Headaches ☐Hearing Problems
☐Heart Palpitations ☐Joint Pain/Swelling ☐Loss of Appetite ☐Loss of Balance ☐Pain at Night
☐Shortness of Breath ☐Urinary Problems/Leakage ☐Vision Problems ☐Weakness in Arms/Legs ☐Weight Gain/Loss

Please list any relevant family history: _____

Surgeries including approximate date: ☐ N/A

_____

_____

_____

Medications (prescription, nonprescription and supplements)
Include frequency and dosage; continue on back if necessary

☐ N/A _____

_____

_____

_____

With whom do you live with? ☐Alone ☐Spouse ☐Child
☐Other Relative ☐Other _____

Where do you live? ☐House ☐Apartment ☐Other_____

Does your home have: ☐ Stairs, w/ railing ☐Ramps
☐Stairs, w/ no railing ☐Uneven Terrain ☐Other _____

Do you use: ☐Cane ☐Walker ☐Manual Wheelchair
☐Motorized Wheelchair ☐Other _____

Allergies: Do you have a latex allergy? ☐Yes ☐No
List other allergies

_____

_____

For Women: Are you pregnant or think you might be pregnant? ☐Yes ☐No

Therapist Initials: _____

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CURRENT CONDITION

Name: _____ Date: _____

When did this problem begin? _____

What happened? _____

Surgery: ☐ Yes ☐ No; If Yes, Type: _____ Surgery Date: _____

Have you ever had this problem before? ☐Yes ☐No If yes, when? _____

If yes, what did you do for the problem? _____

How long did the problem last? _____ Did the problem get better? ☐Yes ☐No

How are you taking care of the problem now? _____

What makes the problem worse? _____

What activities are you not able to do now due to the problem? _____

What are your goals for physical therapy? _____

Are you seeing anyone else for the problem? _____

Clinical Tests Performed for this Condition:

☐Angiogram ☐Bone Scan ☐CT Scan

☐Electrocardiogram ☐MRI ☐Nerve Conduction Test

☐Stress Test ☐Ultra Sound ☐X-Rays

Please rate the level of your pain:

At present: 0 1 2 3 4 5 6 7 8 9 10

At best: 0 1 2 3 4 5 6 7 8 9 10

At worst: 0 1 2 3 4 5 6 7 8 9 10

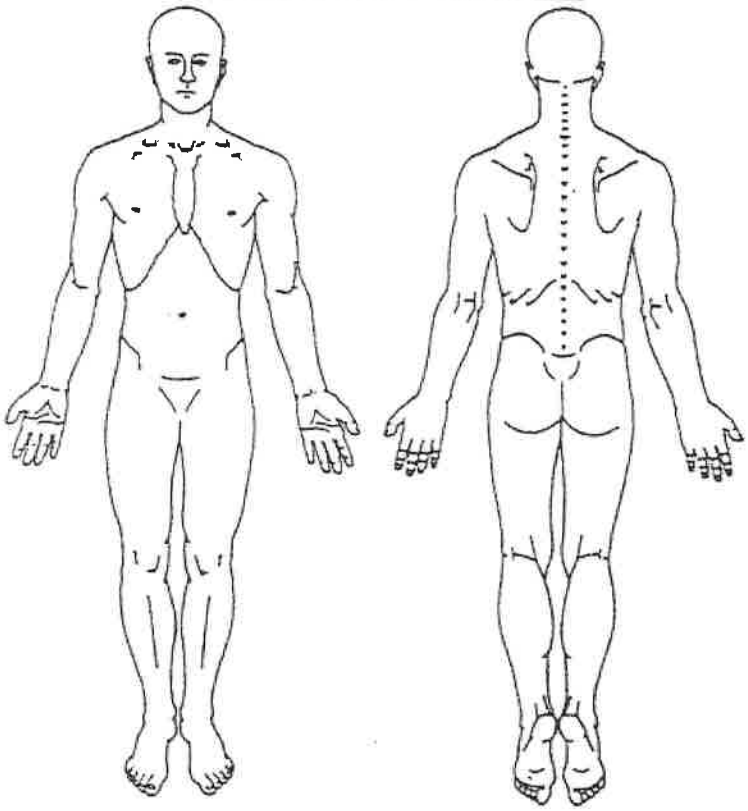
No pain Moderate Extreme

Which of these words describes your pain?
(circle all that apply)

Aching Burning Constant Cramping

Dull Numb Radiating Sharp Tingling

Please mark painful areas:



Therapist Initials: _____

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