



PATIENT INFORMATION

PATIENT NAME (first & last): _____

DATE OF BIRTH: _____ **SSN:** _____

HOME ADDRESS: _____
STREET CITY STATE ZIPCODE

MAILING ADDRESS (skip if same as above): _____

HOME PHONE NUMBER: _____ **CELL PHONE NUMBER:** _____

EMAIL ADDRESS: _____

PLEASE SELECT: MARRIED _____ SINGLE _____ STUDENT: _____ OTHER: _____

DO YOU WANT APPOINTMENT REMINDERS? IF YES, SELECT ONE - **TEXT** _____ **CALL** _____ **EMAIL** _____

EMERGENCY CONTACT NAME: _____ **PHONE:** _____

RELATIONSHIP TO PATIENT: _____

DO YOU HAVE INSURANCE? YES _____ NO _____

PRIMARY INSURANCE NAME: _____

SECONDARY INSURANCE NAME: _____

FINANCIAL RESPONSIBILITY FOR THIS ACCOUNT: (skip if same as above)

NAME (first & last): _____ **DATE OF BIRTH:** _____

MAILING ADDRESS: _____

PHONE NUMBER: _____ **SSN:** _____

WORKER'S COMPENSATION? YES _____ NO _____ **DATE OF INJURY:** _____

EMPLOYER NAME & NUMBER: _____ **CLAIM NUMBER:** _____

ADJUSTER NAME & NUMBER: _____

MOTOR VEHICLE ACCIDENT? YES _____ NO _____ **DATE OF INJURY/ACCIDENT:** _____

AT FAULT _____ **NOT AT FAULT** _____ **CLAIM NUMBER:** _____

INSURANCE COMPANY NAME & ADDRESS: _____

ADJUSTER NAME & NUMBER: _____

Patient or Parent/Legal Guardian Signature

Date

PERSONAL INFORMATION

Since onset of your current symptoms have you had:

- | | |
|---|--|
| <p>Y / N Change in bowel/bladder functions</p> <p>Y / N Dizziness / fainting</p> <p>Y / N Fever / Chills</p> <p>Y / N Malaise (unexplained tiredness)</p> <p>Other: _____</p> | <p>Y / N Night pain / sweats</p> <p>Y / N Numbness or tingling</p> <p>Y / N Unexplained muscle weakness</p> <p>Y / N Unexplained weight change</p> |
|---|--|

Describe how your lifestyle/quality of life has been altered/changed because of this problem:

- Social activity: _____
- Diet / fluid intake: _____
- Physical activity: _____
- Work: _____
- Other: _____

Rate the severity of the problem from 0–10 with 0 being no problem and 10 being the worst: _____

What are your treatment goals? _____

Date of last physical exam: _____

Tests performed during exam: _____

General health (circle one): EXCELLENT GOOD AVERAGE FAIR POOR

Occupation: _____ Hours/week: _____ On disability or leave? _____

Current level of stress (circle one): HIGH MODERATE LOW

Activity/Exercise (circle one): None 1-2 days/week 3-4 days/week 5+ days/week

Medications/Vitamins: _____

Surgical History:

- | | |
|---|--|
| <p>Y / N Abdominal organs</p> <p>Y / N Bladder surgery</p> <p>Y / N Bone / Joint surgery</p> | <p>Y / N Back / Spine surgery</p> <p>Y / N Brain surgery</p> <p>Y / N Female organs</p> |
|---|--|

Other / describe: _____

CHECK ALL THAT APPLY TO CURRENT OR PAST MEDICAL HISTORY:

- | | | |
|---|---|--|
| <input type="checkbox"/> ALCOHOLISM / DRUG PROBLEM
<input type="checkbox"/> ALLERGIES (FOOD / SEASONAL)
<input type="checkbox"/> ANOREXIA / BULIMIA
<input type="checkbox"/> ASTHMA / BRONCHITIS
<input type="checkbox"/> ARTHRITIS
<input type="checkbox"/> BACK PAIN
<input type="checkbox"/> BALANCE / HISTORY OF FALLS
<input type="checkbox"/> BLOOD CLOT
<input type="checkbox"/> BOWEL / BLADDER DIFFICULTY
<input type="checkbox"/> BRUISE / BLEED EASILY
<input type="checkbox"/> CANCER / CHEMOTHERAPY
<input type="checkbox"/> CONSTIPATION
<input type="checkbox"/> COPD
<input type="checkbox"/> DEPRESSION
<input type="checkbox"/> DIABETES
○ TYPE: _____
<input type="checkbox"/> DIZZINESS / FAINTING
<input type="checkbox"/> EPILEPSY / SEIZURES
<input type="checkbox"/> FATIGUE
<input type="checkbox"/> FIBROMYALGIA
<input type="checkbox"/> FOOT/ANKLE PAIN
<input type="checkbox"/> HAND/ELBOW PAIN | <input type="checkbox"/> HEADACHES / MIGRAINES
<input type="checkbox"/> HEART ATTACK
<input type="checkbox"/> HEART DISEASE
○ TYPE: _____
<input type="checkbox"/> HEPATITIS / HIV / AIDS
<input type="checkbox"/> HIGH BLOOD PRESSURE
<input type="checkbox"/> HERNIA
<input type="checkbox"/> IRRITABLE BOWEL SYNDROME
<input type="checkbox"/> INCONTINENCE
<input type="checkbox"/> INFECTIOUS DISEASE
<input type="checkbox"/> JOINT REPLACEMENT
○ TYPE: _____
<input type="checkbox"/> KIDNEY DISEASE
<input type="checkbox"/> KNEE PAIN
<input type="checkbox"/> LATEX ALLERGY / SENSITIVITY
<input type="checkbox"/> LOW BACK PAIN
<input type="checkbox"/> LOW BLOOD PRESSURE
<input type="checkbox"/> MULTIPLE SCLEROSIS
<input type="checkbox"/> NAUSEA
<input type="checkbox"/> NECK PAIN
<input type="checkbox"/> NUMBNESS / TINGLING
<input type="checkbox"/> OSTEOPOROSIS | <input type="checkbox"/> PARKINSON'S DISEASE
<input type="checkbox"/> PELVIC PAIN
<input type="checkbox"/> PHYSICAL / SEXUAL ABUSE
<input type="checkbox"/> SACROILIAC / TAILBONE PAIN
<input type="checkbox"/> SEXUALLY TRANSMITTED DISEASE
<input type="checkbox"/> SHORTNESS OF BREATH
<input type="checkbox"/> SHOULDER PAIN
<input type="checkbox"/> SLEEPING DIFFICULTY
<input type="checkbox"/> SMOKING HISTORY
<input type="checkbox"/> SPEECH DIFFICULTY
<input type="checkbox"/> STROKE
<input type="checkbox"/> SWALLOWING DIFFICULTY
<input type="checkbox"/> SWELLING OF LIMBS
<input type="checkbox"/> THYROID DISEASE
<input type="checkbox"/> VISION / HEARING DIFFICULTY
<input type="checkbox"/> WEAKNESS
<input type="checkbox"/> WEIGHT LOSS
<input type="checkbox"/> OTHER:

_____ |
|---|---|--|

OB/GYN History:

- | | |
|--|---|
| Y / N C-Sections # _____
Y / N Difficult childbirths # _____
Y / N Episiotomy # _____
Y / N Menopause – when? _____
Y / N Painful vaginal penetration | Y / N Painful periods
Y / N Pelvic pain
Y / N Prolapse or organ falling out
Y / N Vaginal deliveries # _____
Y / N Vaginal dryness |
|--|---|



NOTICE OF INFORMATION PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Family Physical Therapy and Sports Center, P.C. is required by federal law to maintain the privacy of Protected Health Information and to provide notice of its legal duties and privacy practices with respect to Protected Health Information. This notice fulfills the "Notice" requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Final Privacy Rule. If you have questions about any part of this Notice of Information Privacy practices or desire to have further information concerning information practices at Family Physical Therapy and Sports Center, P.C., please call us at 308-236-5884 or 308-698-2820.

Acknowledgement of receipt of this notice: I have been informed of the Privacy Policies of Family Physical Therapy and Sports Center, P.C.

Patient or Parent/Legal Guardian Signature

Date

RELEASE OF PERSONAL HEALTH INFORMATION:

IF YOU WISH FOR ANYONE OTHER THAN YOURSELF TO HAVE ACCESS TO YOUR MEDICAL OR FINANCIAL RECORDS, PLEASE LIST THOSE NAMES AND THEIR RELATIONSHIP TO YOU BELOW:

RELEASE TO: _____

RELATIONSHIP: _____



MEDICARE THERAPY CAP FOR 2025

PT & Speech: Beginning January 01, 2025, Medicare has rendered a payment cap for therapy services. Medicare will allow \$2,410.00 for a combination of outpatient physical and speech therapy services. Medicare has also outlined an exception process for this cap amount. If we feel that your condition does not meet the requirements of this exception to the cap, we will inform you of other payment options at the time you have reached your maximum amount with Medicare.

OT: Beginning January 01, 2025, Medicare has rendered a payment cap for therapy services. Medicare will allow \$2,410.00 for outpatient occupational therapy services. Medicare has also outlined an exception process for this cap amount. If we feel that your condition does not meet the requirements of this exception to the cap, we will inform you of other payment options at the time you have reached your maximum amount with Medicare.

SIGNATURE

DATE



MEDICARE THERAPY CAP FOR 2026

PT & Speech: Beginning January 01, 2026, Medicare has rendered a payment cap for therapy services. Medicare will allow \$2,480.00 for a combination of outpatient physical and speech therapy services. Medicare has also outlined an exception process for this cap amount. If we feel that your condition does not meet the requirements of this exception to the cap, we will inform you of other payment options at the time you have reached your maximum amount with Medicare.

OT: Beginning January 01, 2026, Medicare has rendered a payment cap for therapy services. Medicare will allow \$2,480.00 for outpatient occupational therapy services. Medicare has also outlined an exception process for this cap amount. If we feel that your condition does not meet the requirements of this exception to the cap, we will inform you of other payment options at the time you have reached your maximum amount with Medicare.

SIGNATURE

DATE



AUTHORIZATION FOR RELEASE OF INFORMATION AND CONSENT TO TREAT

The undersigned hereby authorizes **FAMILY PHYSICAL THERAPY AND SPORTS CENTER** to furnish from my medical record requested information or excerpts to the referring physicians, if any, and to Medicare, Medicaid, or any insurance company for the purpose of processing claims and to obtain payment of the account for services provided to the patient. By signing, this authorization the patient, parent or legal guardian of the patient hereby gives to medical treatment.

MEDICARE RELEASE

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any authorized benefits be made on my behalf.

FINANCIAL AGREEMENT

The undersigned hereby agrees that, in consideration of the services to be rendered to the patient, to pay **FAMILY PHYSICAL THERAPY AND SPORTS CENTER** in accordance with the regular rate and the offices payment policy. Some insurance companies do not pay for hot/cold packs. These are billable services and due by the patient. **A LATE FEE WILL BE CHARGED TO ALL OVERDUE ACCOUNT BALANCES AFTER 60 DAYS.**

WORKER'S COMPENSATION

PLEASE NOTIFY OFFICE STAFF AT CHECK-IN IF THIS IS A WORKER'S COMPENSATION INJURY

Any patient claiming worker's compensation must bring notice of injury from their employer before it will be turned into worker's compensation insurance. Otherwise, all billing will be submitted to personal medical insurance.

ATTENDANCE POLICY

If you are more than 15 minutes late for your appointment and fail to notify us, treatment may be cancelled. Please give 24 HOUR notice if you need to cancel your appointment. **Three consecutive no-shows** will result in the cancellation of all remaining scheduled appointments. Repeated failure to comply with this **ATTENDANCE POLICY** will result in your name being placed on a "Schedule Based on Availability" list. This will require you to call for an open appointment on each day you would like to receive therapy. We will do everything possible to accommodate you, as space on the schedule permits.

This undersigned certifies that he/she has read the forgoing, and is the patient or duly authorized by or on behalf of the patient to execute the above and accepts its terms.

Patient or Parent/Legal Guardian Signature

Date