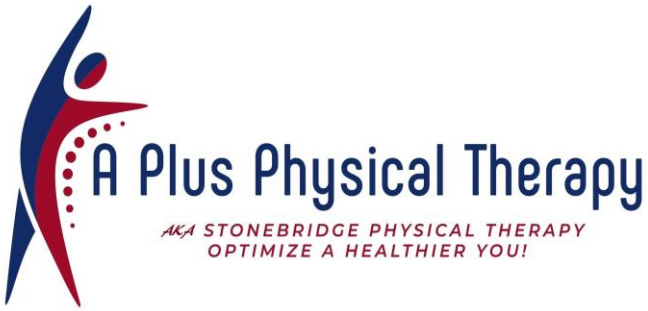
A Plus Physical Therapy

5881 Virginia Pkwy, suite 100,
McKinney, Texas 75071
P:972.548.9993 F:972.548.8485
stonebridgetherapy@gmail.com
info@apluspt.net



The purpose of this questionnaire is to help us understand your health status. Please complete this form and your therapist will answer any question during your exam. This form is considered part of your medical record.

Name: _____ Birth Date/Age: _____
Referring Physician: _____ Family Physician: _____
Currently Working? YES NO Occupation: _____
Have you had surgery for this injury? YES NO Type of surgery/dates: _____
Is an attorney involved in this case? YES NO Attorney Name: _____
Are you currently taking any prescriptions or non-prescription medications? YES NO
Anti-inflammatories Muscle Relaxers Pain Medicines Others: _____

Have you had any of the following Medical or Rehabilitative Care for this Injury/Episode? (Please Circle)

Chiropractor	YES	NO	CT SCAN	YES	NO
General Practitioner	YES	NO	EMG/NCV	YES	NO
Occupational Therapy	YES	NO	MRI	YES	NO
Physical Therapy	YES	NO	Myelogram	YES	NO
Massage Therapy	YES	NO	X-Rays	YES	NO
Neurologist	YES	NO	Emergency Room Care	YES	NO
Orthopedist	YES	NO	Podiatrist	YES	NO

Do you have, or have you ever had, any of the following? (Please Circle)

Asthma, Bronchitis, or Emphysema	YES	NO	Severe or Frequent Headaches	YES	NO
Shortness of Breath/Chest Pain	YES	NO	Vision or Hearing Difficulty	YES	NO
Coronary Heart Disease or Angina	YES	NO	Numbness or Tingling	YES	NO
Do you have a pacemaker?	YES	NO	Dizziness or Fainting	YES	NO
High Blood Pressure	YES	NO	Weakness	YES	NO
Heart Attack/Surgery	YES	NO	Weight loss/Energy Loss	YES	NO
Blood clot/emboli	YES	NO	Hernia	YES	NO
Stroke/TIA	YES	NO	Epilepsy/Seizures	YES	NO
Allergies	YES	NO	Thyroid trouble/Goiter	YES	NO
Pins or Metal Implants	YES	NO	Incontinence	YES	NO
Joint replacement (any)	YES	NO	Bowel or Bladder Problems	YES	NO
Diabetes	YES	NO	Neck Injury/Surgery	YES	NO
Infections diseases	YES	NO	Shoulder Injury/Surgery	YES	NO
Cancer/Chemotherapy/Radiation	YES	NO	Elbow/Hand Injury/Surgery	YES	NO
Arthritis/Swollen Joints	YES	NO	Back Injury/Surgery	YES	NO
Osteoporosis	YES	NO	Knee Injury/Surgery	YES	NO
Sleeping Problems/Difficulty	YES	NO	Leg/Ankle/Foot Injury/Surgery	YES	NO
Do you smoke?	YES	NO	Multiple Sclerosis	YES	NO

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Latex Sensitivity/Allergy	YES	NO	Parkinson's Disease	YES	NO

Additional Comments: _____

FOR WOMEN ONLY:

Pelvic inflammatory Disease	YES	NO	Endometriosis	YES	NO
Irregular Menstrual Cycle	YES	NO	Incontinence (Urinary/fecal)	YES	NO
Complicated pregnancies/Deliveries	YES	NO	Are you pregnant	YES	NO

Patient/Guardian Signature: _____ Date: _____

PT Initials: _____ Date: _____

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DATE: _____

PATIENT NAME: _____
HOME PHONE: _____ CELL PHONE: _____
RESPONSIBLE PARTY (IF MINOR): _____
STREET ADDRESS: _____
CITY, STATE, ZIP CODE: _____
SEX: ( ) FEMALE ( ) MALE AGE: _____ BIRTHDATE: _____

DOCTOR: _____ PHONE: _____
ADDRESS: _____

EMPLOYER: _____ PHONE: _____
EMPLOYER ADDRESS: _____
OCCUPATION: _____
WHO IS RESPONSIBLE FOR THIS ACCOUNT? _____
RELATIONSHIP TO PATIENT: _____
MEDICAL INSURANCE COMPANY: _____
ADDRESS: _____ PHONE: _____
POLICY HOLDER: _____ ID# _____ GROUP#: _____

Other than you and your insurance, who may we talk to about your healthcare information?

Name	Phone Number	Relationship

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED? _____
HOW DID YOU LEARN OF OUR PRACTICE? _____
WHAT WILL WE BE SEEING YOU FOR? _____

INSURANCE ASSIGNMENT AND RELEASE

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I CERTIFY THAT I HAVE INSURANCE COVERAGE WITH: _____
AND ASSIGN DIRECTLY TO A PLUS PHYSICAL THERAPY, LLC ALL INSURANCE BENEFITS, IF ANY OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I AUTHORIZE THE USE OF MY SIGNATURE ON ALL INSURANCE SUBMISSIONS.

THE ABOVE NAME DOCTOR MAY USE MY HEALTH CARE INFORMATION AND MAY DISCLOSE SUCH INFORMATION TO THE ABOVE NAME INSURANCE COMPANY AND THEIR AGENTS FOR THE PURPOSE OF OBTAINING PAYMENT FOR SERVICES AND DETERMINING INSURANCE BENEFITS OR THE BENEFITS PAYABLE FORE RELATED SERVICES.

24-HOUR CANCELLATION POLICY
I UNDERSTAND A PLUS PHYSICAL THERAPY, LLC REQUIRES 24 HOUR CANCELLATION POLICY AND MY CREDIT CARD WILL BE BILLED **$25.00** IF I DO NOT CANCEL MY SCHEDULED APPOINTMENTS.

I CERTIFY TO EVALUATION AND TREATMENT OF MINOR RELATIVE IN MY ABSENCE OF THIS FACILITY.

I HAVE RECEIVED A COPY OF HIPAA REGULATIONS

X_____
SIGNATURE OF BENEFICIARY OR GUARDIAN DATE

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AKA STONEBRIDGE PHYSICAL THERAPY
OPTIMIZE A HEALTHIER YOU!

PLEASE NOTE:

1. We will verify your insurance plan benefits and will attempt to bill your medical insurance for services rendered.

2. If your Insurance plan denies your services, we will be happy to give you a statement to submit to your insurance company.

3. If your Insurance plan benefits DO NOT cover or FULLY cover your treatment, you will be responsible for any deductibles, copays or coinsurance, or a maximum payment of **$120** per treatment hour. (***This may be collected at the time of service***)

4. We are required to send you a billing statement for the insurance benefits not fully covered or denied by your plan.

5. We do our best to work with our patients concerning treatment charges, please let us know if any collected or billed amounts may cause you financial difficulty.

6. **MEDICARE PAITENTS**, you will be responsible for any amount **not covered** or **denied** by your **secondary insurance plan**, if applicable.

Thank you for understanding.

Sincerely,

The people that care and work hard to make you better.

PATIENT'S SIGNATURE _____ DATE _____

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I hereby certify that the statements and answers given on this form are accurate to the best of my recollection and knowledge. I agree to allow this office to examine me for further evaluation. I have received a copy of the HIPAA paperwork and regulations. My signature below verifies this. I understand that I am financially responsible for the services rendered. I hereby authorize payment to be made directly to **A Plus Physical Therapy LLC** for all benefits which may be payable under a healthcare plan or from any other collateral sources. **A Plus Physical Therapy LLC** may use my healthcare information and/or may disclose such information my insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits for related services. **A Plus Physical Therapy LLC** may release all information requested and necessary to my physician(s).

Patient or Authorized Representative

Date