Premier Therapy Centers, Inc.

33010 Northwestern Highway, West Bloomfield, MI 48322
Phone 248.538.5165 • Fax 248.538.5164

Last Name: _____ First Name: _____ MI: _____

Street Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____ Cell Phone: _____

Email Address: _____ Date of Birth: _____

Gender: Male Female Marital Status: M S D W

Emergency Contact Name: _____ Phone Number: _____

Referring Physician: _____ Employment Status: Working Retired Disabled

Employers Name: _____

Employers Address: _____

Primary Insurance: _____ Name of Insured: _____

Subscribers Date of Birth: _____ Relationship to patient: _____

Secondary Insurance (if applicable): _____

IMPORTANT: Patients are responsible to verify their insurance policy's physical therapy benefits. Insurance deductibles and co-pays payments will be collected at the end of each treatment session. **Initials _____**

Is your injury related to: Work? _____ Auto? _____ Liability Claim? _____

Company's Name and Address: _____

Phone Number: _____ Adjuster Name: _____

Claim#: _____ Date of Injury: _____

Is your claim in dispute? If yes explain: _____

_____ _____

Patient or Guardian Signature Date

MEDICAL HISTORY

Name: _____

What is your reason for coming to physical therapy?

_____

_____

Describe your Symptoms.

_____

_____

When did your problem begin?

_____

If it is surgical, what is the date of surgery? _____

Please indicate if you have **EVER** been diagnosed with any of the following conditions:

(answer all questions)

__ Y __ N Cancer. Type & When?: _____
__ Y __ N Heart problems. Type & When?: _____
__ Y __ N Pace Maker: _____
__ Y __ N Circulation problems: _____
__ Y __ N High blood pressure: _____
__ Y __ N Stroke. When & What side was affected?: _____
__ Y __ N Respiratory problems: _____
__ Y __ N Infectious disease: _____
__ Y __ N HIV/AIDS: _____
__ Y __ N Hepatitis. Type?: _____
__ Y __ N Tuberculosis: _____
__ Y __ N Anemia: _____
__ Y __ N Thyroid problems: _____
__ Y __ N Kidney disease: _____
__ Y __ N Diabetes. Type & When diagnosed?:_____
__ Y __ N Epilepsy: _____
__ Y __ N Rheumatoid arthritis: _____
__ Y __ N Osteoarthritis: _____
__ Y __ N Currently pregnant. How many weeks?: _____
__ Y __ N Metal or plastic implants. Where?: _____
__ Y __ N Allergies. Type?: _____
__ Y __ N Other: _____

Please list **ALL** surgeries and dates:

_____

_____

Are you currently seeing any of the following?

__ Y __ N Medical Doctor (MD)
__ Y __ N Osteopath (DO)
__ Y __ N Chiropractor
__ Y __ N Physical Therapist
__ Y __ N Dentist
__ Y __ N Podiatrist

Which of the following OVER-THE-COUNTER medications have you taken in the last week?

__ Y __ N Aspirin
__ Y __ N Tylenol
__ Y __ N Advil/Motrin/Ibuprofen
__ Y __ N Laxatives
__ Y __ N Decongestants
__ Y __ N Antihistamines
__ Y __ N Antacid
__ Y __ N Vitamins/Supplements
__ Y __ N Other:_____

Please list any PRESCRIPTION medication you are currently taking (pills, injections, and/or skin patches):

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Have you recently noted:
__ Y __ N Weight loss/gain
__ Y __ N Nausea/vomiting
__ Y __ N Fatigue
__ Y __ N Weakness
__ Y __ N Fever/chills/sweats
__ Y __ N Numbness or tingling

_____ _____
Patient Signature Date Therapist Signature Date

CONSENT FORM

CONSENT TO TREATMENT
I consent to rehabilitation and related services at PREMIER THERAPY CENTERS. In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touch and/or direct contact of a sensitive nature. Initials _____

LIABILITY
I know and agree that PREMIER THERAPY CENTERS is not responsible for loss or damage to personal valuables. Initials _____

WAIVER AND RELEASE
I hereby release, discharge and acquit PREMIER THERAPY CENTERS its agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care service. Initials _____

AUTHORIZATION OF PAYMENT
I hereby assign all benefits directly to PREMIER THERAPY CENTERS. I also authorize release of any medical records to other healthcare providers as necessary to facilitate my treatment and to other third parties as necessary to process medical claims and otherwise permitted or required in the Notice of Privacy Practices.
Initials _____

FINANCIAL POLICY
I understand fully in the event my insurance company or financially responsible party does not pay for the services I receive; I will be financially responsible for payment. To assist in establishing your account, please:

- Supply all necessary information for accurate billing of your claim, including your insurance card, driver's license, employer information, and demographic information.
- Satisfy all insurance co-payments, co-insurance, deductibles, and non-covered services on the day services are rendered.
- Provide your insurance company and us with any additional information requested to complete the processing of claims filed on your behalf Initials _____

TREATMENT OF MINORS
I, as a parent/guardian of a minor receiving treatment hereunder, do herby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. Initials _____

NOTICE OF PRIVACY/PATIENT BILL OF RIGHTS

I acknowledge receipt of Notice of Privacy Practices. Initials _____

I acknowledge receipt of the Rehabilitation Care Clients Bill of Rights Initials _____

I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature _____ Date _____