Neuro Fitness Therapy

PLEASE PRINT CLEARLY

DATE_____

PATIENT NAME (first)_____(initial)____(last)_____

ADDRESS_____CITY_____STATE____ZIP_____

HOME PHONE (___)_____E-MAIL ADDRESS_____

PATIENT DATE OF BIRTH_____AGE____SOCIAL SECURITY #_____

PATIENT EMPLOYER_____

EMPLOYER ADDRESS_____CITY_____STATE____ZIP_____

WORK PHONE (____)_____OCCUPATION_____

INSURED'S NAME (first) _____(initial)____(last)_____

INSURED'S ADDRESS_____CITY_____STATE____ZIP_____

INSURED'S HOME PHONE (___)_____E-MAIL ADDRESS_____

INSURED'S DATE OF BIRTH_____AGE____SOCIAL SECURITY #_____

RELATION TO PATIENT_____INSURED'S OCCUPATION_____

INSURED'S EMPLOYER_____WORK PHONE (____)_____

EMPLOYER ADDRESS_____CITY_____STATE____ZIP_____

NAME OF EMERGENCY CONTACT_____

ADDRESS_____CITY_____STATE____ZIP_____

PHONE (___)_____RELATION TO PATIENT_____

HOW DID YOU HEAR ABOUT US?_____

I, the undersigned, understand that an attempt will be made by this office to bill my insurance carrier for the physical therapy treatments rendered to me. However, should difficulties arise concerning reimbursement from my insurance carrier (example: partial payment, unreasonable time lapse, denial of payment for any reason, deductible, co-insurance, or any other balance not paid by my insurance) for whatever reason, I understand that I am financially responsible for all charges whether or not paid by my insurance. It is the policy of **Neuro Fitness Therapy** Inc., to submit claims for patients according to the information supplied by the patient. Without current, complete and accurate information, I understand that I am responsible for payment of any remaining balance. I understand that any co payment due by me is collected by this office at the time services are rendered. I understand that this office ***does not*** bill secondary insurance and it is my responsibility to collect any amount due to me by secondary insurance. I agree to pay a late charge of $20.00 on any unpaid balance for which I have been billed that is not paid in a timely manner. I hereby authorize **Neuro Fitness Therapy** Inc. to release any and all information necessary to secure payment.

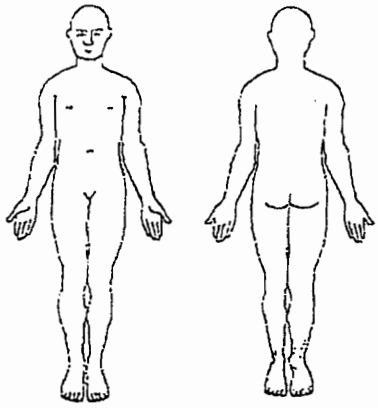
PATIENT SIGNATURE (Parent if Minor)_____Date_____

Neuro Fitness Therapy

Hockessin
Stone Mill Plaza
720 Yorklyn Road
Suite 150
Hockessin, DE 19707
302-234-2288 Tel
302-234-2869 Fax

North Wilmington
Lombardy Center
410 Foulk Road
Suite 106
Wilmington. DE 19803
302- 764-2288 Tel
302-234-2869 Fax

Please shade in areas where pain or abnormal sensations are present.



History of Present Condition

1. What are your symptoms?

_____

_____

When did your symptoms begin? _____

2. Please rate your current pain level on the scale below:

0——|——|——|——|——|——|——|——|——|——10

No Pain **Worst Possible Pain**

At its worst, pain level is a _____
At its best, pain level is a _____

3. Have you had any previous treatment for this condition? (Check all that apply)

- ☐ None
- ☐ Physical therapy
- ☐ Joint manipulation
- ☐ Exercise
- ☐ Massage therapy
- ☐ Traction
- ☐ Bracing/taping
- ☐ Injection into the spine
- ☐ Casting
- ☐ Injection into the skin/muscles
- ☐ Other_____
- ☐ Medication (oral)
- ☐ Hypnosis
- ☐ Biofeedback
- ☐ TENS unit
- ☐ Acupuncture
- ☐ Bed Rest
- ☐ Overnight hospitalization

4. Have you had any of the following tests?

- ☐ X-Rays
- ☐ CT Scan
- ☐ MRI
- ☐ Arthrogram
- ☐ Stress X-Ray Test (Telos)
- ☐ Other_____
- ☐ Bone Scan
- ☐ NCS
- ☐ Fluoroscope
- ☐ Vestibular

Test Results: _____

Medication

Please list any **prescription** medications you are currently taking (pain pills, injections and/or skin patches etc):

_____

_____

_____

_____

_____

Prescribing MD: _____

Are you currently taking any of the following over the counter medications?

- ☐ Aspirin
- ☐ Tylenol
- ☐ Antihistamines
- ☐ corticosteroids
- ☐ other_____
- ☐ Vitamins/mineral supplements
- ☐ Advil/Motrin/Ibuprofen

Fall History

Have you fallen in the last 12 months?

_____

Past Medical History

Have you ever had/ been diagnosed with any of the following conditions?

- ☐ Cancer (type)_____
- ☐ High blood pressure
- ☐ Stroke
- ☐ Kidney problems
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Arthritis
- ☐ Stomach problems
- ☐ Circulation/vascular problems
- ☐ Parkinson's Disease
- ☐ Infectious Diseases (i.e. hepatitis, tuberculosis)
- ☐ Rheumatoid Arthritis
- ☐ Multiple Sclerosis
- ☐ Other_____
- ☐ Heart problems
- ☐ Lung problems
- ☐ Blood disorders
- ☐ Epilepsy/Seizures
- ☐ Allergies
- ☐ Osteoporosis
- ☐ Head Injury
- ☐ Broken bone

Please list any recent/relevant past surgeries related to your current problem:

Surgery	Date

Family History

Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the following?

- ☐ Osteoporosis
- ☐ Heart disease
- ☐ Stroke
- ☐ Psychological conditions
- ☐ Cancer
- ☐ Arthritis
- ☐ High Blood Pressure
- ☐ Other_____

Neuro Fitness Therapy

YOUR BENEFITS
*****IMPORTANT*****

We CANNOT guarantee that the insurance benefit information we obtain from your insurance carrier is correct. For this reason, we require you to contact your insurance carrier to confirm your specific benefits. We make every attempt to accurately confirm your financial responsibility for your rehabilitation and provide this information to you in the form of a copy of the Benefits Confirmation sheet. Please refer to this sheet if you have a question regarding the information given to us by your insurance provider, such as the amount of your deductible, if that is a feature of your coverage. Since your provider applies claims against your deductible from various sources, we can not track this amount for you. It is your responsibility to be aware of your deductible amount, as well as any/all financial responsibilities you may incur.

Co-pay and coinsurance charges are based on the information your insurance company provides when we call for your benefits, however, the amounts are estimates. The final amounts due are determined by your insurance company at the time the claims are received and processed, and sometimes this amount differs from what we collect at the time of service.

Performance Physical Therapy and Fitness, Inc. does not bill secondary insurance companies in cases other than Medicare patients. Please contact your PRIMARY insurance company and request them to crossover your co-pay responsibility to your SECONDARY insurance carrier.

It is understood that the FINAL DETERMINATION OF CO-PAY/COINSURANCE RESPONSIBILITY is taken from the Explanation of Benefits received from the patient's insurance company. The patient is aware that he/she may owe more as a result of the above procedure.

The patient further fully understands that he/she will be billed and financially responsible for any and all charges not paid by their insurance company. A late charge of $20.00 will be assessed to any unpaid balance for which they have been billed that is not paid in a timely manner.

ATTENDANCE POLICY

It is important that you keep your scheduled appointments. You are more likely to see steady progress and maximize your insurance coverage by attending consistently. Your regular attendance also allows us to meet the needs of all of our patients effectively.

If you have a scheduled appointment that must be cancelled, please provide at least 4 hours advance notice to avoid a $25.00 cancellation fee. Payment of the cancellation fee is expected at your next scheduled appointment.

Thank you for your cooperation in helping us to treat you and others as effectively as possible. Please sign below to indicate that you understand our attendance policy.

PRIVACY POLICY

I have been offered and read a copy of this facility's privacy policy. (Effective April 14, 2003)

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS.

Signature (parent or guardian if under 18): _____

Date: _____