**Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Therapist:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

M.I.

First

Last

**Mailing Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

State

Zip

City

Street

**Birth Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: Male Female Marital Status:\_\_\_\_\_\_\_\_\_\_\_\_**

(Please Circle One)

**Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Would you like a reminder of future appointments? Yes No**

(Please Circle One)

**If so, would you prefer a: Call Text E-Mail Date of Injury/Onset:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(Please Circle Only One)

**Body part(s) to be treated:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Is this work related? Yes No Is this related to an Auto Accident? Yes No**

(Please Circle One)

(Please Circle One)

**Referring Provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Person we can contact in the event of an emergency:**

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I plan to make a payment of any non-covered medical costs by: ( )Cash/Check ( )Master Card ( )Visa**

**If you are not the subscriber on your insurance, please complete the following section with subscriber’s information:**

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Mailing Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(If different than patient)

State

Zip

City

Street

**Home #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I authorize the release of any medical information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. I authorize payment of medical benefits to physician or supplier for service:

**Signed**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Insured or Authorized Person)

United Physical Therapy Office Policies

1. It is your responsibility to notify your insurance company you will be attending physical therapy. We recommend you also inquire about your carrier’s specific coverage. We will precertify your visits with your insurance if necessary as a courtesy. Any charges not covered by insurance, **including treatment your insurance company deems not medically necessary, will be your financial responsibility.** United Physical Therapy is not responsible for tracking insurance benefits. You are responsible for any deductible, co-insurance, or co-payment at the time of service.
2. **If your out-of-pocket expenses are 90 days or more past due, your account may be turned over to collections.** You will be responsible for the account balance plus an additional interest rate of 0.875% per month to cover the cost associated with collections.
3. It is your responsibility to notify United Physical Therapy of any changes to your insurance carrier or plan. **If you do not provide us with the correct insurance information at the time of your appointment, you will be financially responsible** for the resulting unpaid bills.
4. You are responsible for payment of any supply issued by United Physical Therapy. We **will not** bill your insurance for any supplies. All sales of supplies are final. **We do not accept returns or issue refunds for supplies.**
5. If you cancel without 24 hours notice and/or “no show” for a total of three appointments, your therapist may choose not to see you as a patient any longer.
6. Children must be accompanied by an adult at all times. They can be brought to the treatment room or accompanied in the waiting room. Children are not allowed in the gym area.

**\*\*When you arrive, please sign in even if you are not a new patient.\*\***

I have read and I understand the above guidelines.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Facility Name: United Physical Therapy**

By signing below, I acknowledge that I have received, or have had the opportunity to receive, a copy of United Physical Therapy’s Notice of Privacy Practices (“Notice”); which describes how my health information is used and shared. I understand that United Physical Therapy (“UPT”) has the right to change this Notice at any time. I may obtain a current copy by contacting the Facility Privacy Official, or by visiting the UPT web site at www.unitedpt.com

Signature of Patient or Personal Representative \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_

Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Personal Representative’s Title *(e.g., Guardian, Executor of Estate, Health Care Power of Attorney)* ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Initial all statements that apply:**

\_\_\_\_\_ I authorize UPT to leave messages regarding my appointments on my home answering machine.

\_\_\_\_\_ I authorize UPT to leave voicemails regarding my appointments on my personal cell phone.

\_\_\_\_\_ I authorize UPT to discuss my appointments and my billing account with the following individuals:

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**For Facility Use Only: Complete this section if you are unable to obtain a signature.**

1. If the patient or personal representative is unable to sign this Acknowledgement, or the Acknowledgement is not signed for any other reason, state the reason: 2. Describe the steps taken to obtain the patient’s or personal representative’s signature on the Acknowledgement:

**Completed by: Signature of Facility Representative Date**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_



**South Midtown Downtown**

Els Brady, PT, MOMT Hal Egbert, PT, OCS Alec Kay, PT, DMT, OCS, ATC.

Kelsey Granley, PT, DPT, CDN Els Brady, PT, MOMT Anne Blount, DPT

Erin Danielson, PT, DPT, OCS, Luci Bennett, PT, MOMT, OCS John Polonowski, PT, FAAOMPT

COMT Jo Young, PT, DPT, CMP Bryan Templeman, DPT, ATC

Lori Sivitz, PT Leah Ruggirello, PT DPT, OCS, Barb Smith, PT, CHT FAAOMPT

Dennis Poirier, PT, MOMT, OCS

Staci Deschamps Griffin, DPT

701 Sesame Street. Suite 101, Anchorage, AK 99503 midtown@unitedpt.com (907) 561-2260 FAX 561-0448

742 K Street, Anchorage, AK 99501 downtown@unitedpt.com (907) 929-8400 FAX 929-8403

12570 Old Seward Hwy, Suite 202, Anchorage, AK, 99515 south@unitedpt.com (907) 222-2886 FAX 222-2889

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­\_\_\_\_\_\_\_\_\_\_ Patient ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Statement Preference**

As a courtesy, United Physical Therapy will gladly bill your insurance company, provided we have your current insurance information on file. It is your responsibility to know the limitations associated with your insurance policy. There are several reasons you may have a balance after your insurance processes your claim, including deductible, co-insurance, co-payment, or failure to obtain a referral or authorization prior to your appointment. You are responsible for any unpaid balance on your account. By signing below, you assume financial responsibility for care rendered or services provided by United Physical Therapy. Please indicate how you would like to receive your billing statement. An emailed statement can be paid online.

\_\_\_\_\_Mailed Statement Mailing Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_Emailed Statement Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(online payment option)

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**UNITED PHYSICAL THERAPY MEDICAL HISTORY FORM**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Reason for visit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Name of referring physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Name of other providers (chiropractors, physical therapists, physicians, etc) that you’ve seen for your current condition? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Medical History:**

Have you ever had any of the following conditions? Check all that apply.

□High blood pressure □Heart condition □Stroke □Osteoporosis

□Peripheral Neuropathy □Seizures/epilepsy □Vision problems □Diabetes

□Hearing problems □Fainting/dizziness □Emphysema □Asthma

□Cancer □Thyroid problems □Arthritis □Lupus

□Frequent or severe headaches □Bowel/bladder problems

□Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any falls in the past year? YES NO If so, about how many? \_\_\_\_\_\_\_\_\_\_\_\_

Do you have a history of fractures? YES NO Where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any metal implants? YES NO Where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke? YES NO How much per day?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you exercise regularly? YES NO How often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any known allergies? YES NO Please list\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications:**

Please list any medications/supplements (prescribed or over-the-counter) that you are currently taking:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Surgeries**: Please list all surgeries (include dates):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Diagnostic Tests:** Please check any tests or procedures that have been done for your **current** condition.

□X-rays □MRI □CT scan □Bone scan

□EMG □Blood work □Bone density □Ultrasound

**Doctor(s) who ordered the Diagnostic Tests: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Current Condition**

* What is the date when the problem started? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Have you had similar symptoms before? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Have you had previous treatment for this condition? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Does your pain limit any of the following activities:**

□Lifting from the floor □Sitting □Head motion □Shopping

□Lifting overhead □Standing □Twisting □Doing dishes

□Reaching □Walking □Bending □Housework

□Stairs □Sleeping □Squatting □Yardwork

***Please rate your pain level you are experiencing right now. 0= none, 10= severe***

0 1 2 3 4 5 6 7 8 9 10

***What is the highest pain level you had in the past week?***

0 1 2 3 4 5 6 7 8 9 10

***What is the lowest pain level you had in the past week?***

0 1 2 3 4 5 6 7 8 9 10

Please list any important activities that you are unable to do or are having difficulty with as a result of your current problem. Please rate each of these problems on the 0-10 scale below.

**0= Unable to perform the activity (cannot perform)**

**10= Ability to perform activity at the same level as before the injury or problem (no issues)**

***Activity\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***0 1 2 3 4 5 6 7 8 9 10***

(cannot perform) (No issues)

***Activity\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***0 1 2 3 4 5 6 7 8 9 10***

(cannot perform) (No issues)

***Activity\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***0 1 2 3 4 5 6 7 8 9 10***

(cannot perform) (No issues)

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_