

# Medical History

Name: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

## Existing or Relevant Previous Conditions (Circle Yes or No)

Alzheimer's	Yes/No	Muscular Dystrophy	Yes/No	Muscular Disease	Yes/No
Cardiovascular Disease	Yes/No	Obesity	Yes/No	Osteoporosis	Yes/No
Cauda Equina Syndrome	Yes/No	Osteoarthritis	Yes/No	Seizures	Yes/No
Cerebral Vascular Accident	Yes/No	Parkinson's	Yes/No	Strokes	Yes/No
Current Infection	Yes/No	Rheumatoid Arthritis	Yes/No	Tuberculosis	Yes/No
Diabetes Mellitus Type 1	Yes/No	Traumatic Brain Injury	Yes/No	Allergies/Asthma	Yes/No
Diabetes Mellitus Type 2	Yes/No	Lupus	Yes/No	Pacemaker	Yes/No
Fibromyalgia	Yes/No	Smoker	Yes/No	Metal Implants	Yes/No
Fracture/ Suspected Fracture	Yes/No			HIV/AIDS	Yes/No
High Blood Pressure	Yes/No			Currently Pregnant	Yes/No
History of Cancer	Yes/No			Anxiety	Yes/No
Huntington's	Yes/No			Headaches	Yes/No
Immunosuppression	Yes/No			Are you or have you been treated for depression?	Yes/No

## Surgical History

Body Region: \_\_\_\_\_ Surgery Type: \_\_\_\_\_ Date: \_\_\_\_\_

Body Region: \_\_\_\_\_ Surgery Type: \_\_\_\_\_ Date: \_\_\_\_\_

Body Region: \_\_\_\_\_ Surgery Type: \_\_\_\_\_ Date: \_\_\_\_\_

## Current Medications

Drug: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_ Route: \_\_\_\_\_ Reason Taking: \_\_\_\_\_

Drug: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_ Route: \_\_\_\_\_ Reason Taking: \_\_\_\_\_

Drug: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_ Route: \_\_\_\_\_ Reason Taking: \_\_\_\_\_

Additional Information:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Injury as result of a fall in the past year? \_\_\_\_\_

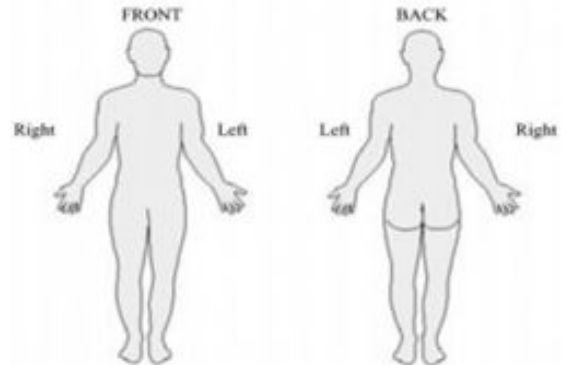
Two or more Falls In the last year? \_\_\_\_\_

## Pain Diagram

☆ Shade in affected area(s).

☆ Label type of sensation or pain in each area

Example: Burning, aching, throbbing, stabbing, tingling, numbness, etc.



Draw a line on the pain intensity scale at the point that best describes your pain at the PRESENT time:

\_\_\_\_\_

0(No Pain) 1 2 3(Mild) 4 5(Moderate) 6 7(Severe) 8 9(Excruciating) 10 (Pain as bad as it could be)

## **FERRELL-WHITED PHYSICAL THERAPY FINANCIAL POLICY – 2023**

**INSURANCE:** To properly bill your insurance company, we require that you disclose ALL insurance information including primary and secondary insurance, as well as any change of insurance information. Ferrell-Whited will contact your insurance company prior to services as a courtesy to verify insurance coverage; however, it is not a guarantee of benefits. You are responsible for all charges regardless of your existing medical coverage. If you are not insured by a plan we participate in, you are responsible for out-of-network rates. Your medical claim will be forwarded to your secondary insurance (if any) after payment and/or explanation of benefits (EOB) is received from your primary insurance company.

**\*Payment for approved services depends on your plan's benefit limitations and eligibility at time of service. Call the Customer Service number on the back of your insurance ID card to learn about what your plan covers, your costs, and to verify your eligibility.**

**NO-SHOW/CANCELLATION POLICY:** We understand there are times when you must miss an appointment due to an emergency. However, your doctor has prescribed physical therapy for you, and this is an on-going process which requires regular attendance. If you are late for an appointment, you may have to reschedule or accept an abbreviated treatment for that day. If you cancel/no-show three appointments, FWPT has the right to discharge you from care. ***You understand and agree that FWPT requires a 24-hour advance notice of cancellation. IF YOU FAIL TO GIVE 24-HOUR NOTICE OF CANCELLATION OR NO-SHOW AN APPOINTMENT, YOU WILL BE RESPONSIBLE FOR A \$50.00 CHARGE (WHICH IS NOT COVERED BY INSURANCE).***

**DELINQUENT ACCOUNTS/COLLECTIONS:** Outstanding patient responsibilities must be paid by you within 30 days after the date of the invoice sent to you. Failure to pay your invoice within 30 days will result in interest charged on your account in the amount of 2.0% per month. Account balances over 90 days will be sent to collections after no response from the patient. Statements will be mailed once per month for three months before becoming delinquent. **It is the patient's responsibility to inform the staff of any changes in address or insurance information. If not notified of insurance changes on or before new effective date, any claim denials will be the responsibility of the patient.**

**COPAYMENTS AND DEDUCTIBLES:** All co-pays must be paid at the time of service.

**MEDICARE:** We are a participating Medicare provider. **Per Medicare guidelines patients who are receiving in-home health care are not eligible for outpatient physical therapy services at the same time.** It is your responsibility to inform FWPT immediately if in-home health care services will be utilized at any time during treatment at FWPT.

**WORKERS COMPENSATION:** This office is a certified Ohio Bureau of Worker's Compensation provider and accepts approved claims. Any Disallowed Claim fees will be the patient's responsibility.

**NON-COVERED SERVICES:** Please be aware that some of the services you receive may not be covered by Medicare or other insurers. We will provide you with an advance beneficiary notice (ABN) for any services that Medicare or other insurers will not cover prior to providing the service to you. Such non-covered services will require your prior approval before they are provided. **You are responsible for payment of these services at the time the service is provided.**

**BILLING SERVICE:** Our billing company will be processing all claims and is responsible for sending out patient statements. Please phone our billing service at **330-722-3781** for any questions concerning your statement balances and payments made on your account. Please let the billing office know if you have any difficulties resolving your bill. If your insurance company should happen to send payment to you, the patient, we expect that you would forward it to our office to be applied to your balance.

**NON-SUFFICIENT CHECKS RETURNED:** For patient payments that are returned due to non-sufficient funds a \$35.00 charge will be added to your bill.

FWPT requires patients that wish to make partial payments on a delinquent account to enter into a monthly payment agreement. The agreement requires the patient to make minimum payments to prevent the account from being sent to collections. **The monthly payment must be at or equal to twenty-five percent (25%) of the total outstanding delinquent balance to fulfill the agreement, unless otherwise agreed by FWPT in the partial payment agreement.** All partial payments less than the required minimum submitted shall go towards the balanced owed. However, these insufficient partial payments will not prevent the collections process unless outlined specifically in the payment agreement between FWPT and the patient.

Additionally, FWPT may restrict the scheduling of non-emergent and non-urgent services for individuals with delinquent accounts as deemed necessary.

I agree to be responsible for payment of all services rendered on my behalf or that of my dependents. I acknowledge and accept this Financial Policy.

**PRINT** Patient Name: \_\_\_\_\_

**Signature** of Patient: \_\_\_\_\_  
*(Parent or legal guardian must sign if patient is under 18 years of age.)*

Relationship to Patient: \_\_\_\_\_ Date: \_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

Ferrell Whited Physical Therapy Services reserves the right to modify the privacy practices outlined in the notice. I have received a copy of the Notice of Privacy Practices for Ferrell Whited Physical Therapy Services.

**PRINT** Name of Patient: \_\_\_\_\_

**Signature** of Patient: \_\_\_\_\_  
*(Parent or legal guardian must sign if patient is under 18 years of age.)*

Relationship to Patient: \_\_\_\_\_ Date: \_\_\_\_\_

<p><b>OFFICE USE ONLY</b> Documentation of Attempt to Obtain Acknowledgment of Receipt of Privacy Practices Date: _____ The acknowledgment was not obtained because the patient declined to sign the acknowledgment. _____ Other Reason: _____ Name of Patient: _____ Name of FWPT Employee: _____</p>
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Employer: \_\_\_\_\_ Occupation \_\_\_\_\_  
*(Required for Workers Compensation Cases)*

Emergency Contact : \_\_\_\_\_ Phone No. \_\_\_\_\_ Relation \_\_\_\_\_

**CONSENT FOR TREATMENT**

I hereby consent to and authorize all therapy treatments, which in conjunction with the judgment of my attending physician, may be considered necessary and/or advisable for the diagnosis and/or treatment of the patient named above at Ferrell-Whited Physical Therapy Services.

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

*(Parent or legal guardian must sign if patient is under 18 years of age)*

Relationship to Patient (circle one):    Self        Mother        Father        Spouse        Legal Guardian