Patient Information

Name (Last) (First)	Biological Sex ☐ M ☐ F	Date of Birth / /	Height	Weight

Treating Physician	Date of next MD appointment / /	Hand Dominance ☐ Left ☐ Right

What brought you to physical therapy?

When did your symptoms start?

Did an accident or specific incident occur causing your symptoms?

Have you previously experienced these symptoms?

Did you have surgery for this issue? ☐ Yes ☐ No
If yes, what procedure did you have done? What was the date of the procedure?

Have you had medical testing?

	Date
X-Ray	/ /
MRI	/ /
EMG	/ /
CT Scan	/ /
Other _________	/ /

Have you had treatment for your symptoms?

	Date
Physical Therapy	/ /
Massage	/ /
Chiropractic	/ /
Injection	/ /
Medication	/ /
Other_________	/ /

Current Complaints

Mark your location of pain, discomfort, weakness, or issue with an "X".

McGill Pain Questionnaire
Mark with an X the exact location of your pain.
(Melzack & Torgerson, 1971)

If you have pain, what is your pain level? (0=no pain, 10=extreme pain)

0-10 Numeric Pain Rating Scale
Currently: 0 1 2 3 4 5 6 7 8 9 10 (No pain — Moderate pain — Worst possible pain)

0-10 Numeric Pain Rating Scale
At best: 0 1 2 3 4 5 6 7 8 9 10 (No pain — Moderate pain — Worst possible pain)

0-10 Numeric Pain Rating Scale
At worst: 0 1 2 3 4 5 6 7 8 9 10 (No pain — Moderate pain — Worst possible pain)

How often do you experience your pain?
- ☐ Constantly (100%)
- ☐ Frequently (60%-90%)
- ☐ Occasionally (30%-60%)
- ☐ Intermittently (5%-30%)

Please describe the type of pain you are experiencing (check all that apply):
- ☐ Sharp ☐ Burning
- ☐ Achy ☐ Shooting
- ☐ Dull ☐ Deep
- ☐ Numb ☐ Superficial
- ☐ Tingling ☐ Other ___________

Is your pain more severe at a certain time of the day? If yes, when?

Has your pain changed since the start of the injury/episode?
☐ Improving ☐ Worsening ☐ Remains the same

Does your pain cause difficulty sleeping?
☐ Yes ☐ No

Functional Abilities and Restrictions

What activities were you able to perform prior to this injury/episode that you are currently unable to perform?

Does any activity make your pain better?	Does any activity make your pain worse?

Work/Social History

Occupation(s):	Position/Job Duties:

Past Medical History

How would you classify your general health? ☐ Excellent ☐ Fair ☐ Good ☐ Poor	Do you smoke cigarettes? ☐ Yes ☐ No If yes, how many cigarettes/day?	Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks and how often?	Please list ALL surgical history and dates.

In terms of your general health, please check all that apply.
Do you currently have or have you ever had any of the following?

☐ Allergies	☐ Cardiac (Heart) Condition	☐ Heart Attack	
☐ Anemia	☐ Chronic Pain (CRPS/RSD)	☐ Hernia	☐ Shortness of Breath
☐ Anxiety/Depression	☐ Current Pregnancy (Due Date)	☐ High Blood Pressure	☐ Stroke/TIA
☐ Arthritis/Osteoarthritis/Rheumatoid	☐ Diabetes (Type I or Type II)	☐ Low Blood Pressure	☐ Thyroid Condition
☐ Asthma/Bronchitis/Emphysema	☐ Dizziness/Fainting	☐ Metal Implant/Jt Replacement	☐ Vision/Hearing Difficulties
☐ Autoimmune Disorder	☐ Epilepsy/Seizure Disorder	☐ Night Pain	☐ Vertigo
☐ Bladder and/or Bowel Issues	☐ Fatigue	☐ Osteoporosis/Osteopenia	☐ Weakness
☐ Blood Clot/Emboli	☐ Fibromyalgia	☐ Pacemaker	☐ Weight loss
☐ Cancer/Chemotherapy/Radiation	☐ Headaches/Migraines	☐ Pelvic Floor Concerns	☐ Other

Medications

Please list all current medications, dosage, and frequency.

Patient Therapy Goals

What are your goals at the completion of Physical Therapy?

Signatures

To the best of my knowledge, I have fully informed my physical therapist as well as all necessary staff and personnel employed by Evolve Physical Therapy the history of my problem and current status.

Patient name (printed)	Patient signature	Date
Parent/Guardian name (printed)	Parent/Guardian signature	Date

Patient Information

Name (Last)	(First)
Address	City, State Zip
Date of Birth / /	Home Phone ( ) Work Phone ( ) Cell Phone ( )
Email	

Emergency Contact

Name (Last)	(First)	
Home Phone ( )	Cell Phone ( )	Work Phone ( )

Relation to Patient: ☐ Spouse ☐ Parent ☐ Child ☐ Other

Primary Insurance

Carrier Name:	Deductible:
ID Number:	Coinsurance:
Group Number:	Max Visits:
Subscriber Name:	Copay:
Subscriber Date of Birth:	Authorization Number:

Subscriber Relation to Patient: ☐Self ☐Spouse ☐Parent ☐Other

Employer Information

Name of Employer	
Address	City, State Zip

Secondary Insurance

Carrier Name:	Deductible:
ID Number:	Coinsurance:
Group Number:	Max Visits:
Subscriber Name:	Copay:
Subscriber Date of Birth:	Authorization Number:

Subscriber Relation to Patient: ☐Self ☐Spouse ☐Parent ☐Other

Treatment History

Have you ever been treated at Evolve Physical Therapy? ☐ Yes ☐ No

Have you had any of the following treatments within the past year? (check all that apply)

☐ Physical Therapy ☐ Occupational Therapy ☐ Chiropractic ☐ Speech Therapy ☐ Other __________

Have you previously had physical therapy for this condition?

☐ Yes ☐ No If yes, for how long? ____

For Medicare Patients Only

Are you currently receiving home care services? ☐ Yes ☐ No

If yes, when will you be discharged from home care? / /

Do you have a home care discharge letter? ☐ Yes ☐ No

For Student Athletes Only

What sport(s) does the student athlete play? ____

Was the student athlete injured during play? ☐ Yes ☐ No If yes, what was the date of the injury? / /

Was the athlete hurt at school or in a league? ____

Was any accident report filed with the school or league? ☐ Yes ☐ No Name of school or league: ______________________

Motor Vehicle Accident Injuries Only

If you are receiving care for injuries from a motor vehicle accident, in what state did the accident occur? ______________________

Claim Number:

Patient or Guardian Agreements

Please initial next to ALL that apply:

_______ I acknowledge that Evolve Physical Therapy may disclose protected health information for the purpose of payment, treatment, and healthcare operations.

_______ **Consent to Treatment:** I consent to receive outpatient physical therapy services that are deemed medically necessary or appropriate by my physical therapist or physical therapist assistant. I am aware that the practice of rehabilitation therapy is not an exact science and I acknowledge that no guarantees have been made to me regarding treatment and the treatment results from the rehabilitation therapy. I understand that I have the right to ask questions at any time during my course of care.

_______ **Consent to Treat a Minor**: Patient Name: ____________________________ Patient DOB: ____/____/_____
The undersigned does hereby authorize Evolve Physical Therapy consent to evaluate and treat the above mentioned minor by employees of Evolve Physical Therapy with or without a Parent or Guardian present.

_______ I agree to pay Evolve Physical Therapy all amounts that are due and owing for services provided which are not otherwise paid for by Medicare, a third party payor, or other payor source on my behalf for services rendered. In the event that this account is referred to a collection agency or attorney, the undersigned further agrees to pay all reasonable costs of collection including, but not limited to, reasonable attorney's fees.

_______ In conjunction with my care, I consent to allow the use of filming devices, such as a camera or cell phone, for the purposes of enhancing my care. In addition, I consent to the transmittal of such filming device images or video to Evolve Physical Therapy and/or the treating physician through email or text. I acknowledge that such film and related images will only be used or disclosed for treatment purposes, and that Evolve Physical Therapy will not further use or disclose such film or images for any other purpose without my authorization or consent.

Patient name (printed)	Patient signature	Date
Parent/Guardian name (Printed)	Parent/Guardian signature	Date

Attendance Policy

(Please read thoroughly)

Evolve Physical Therapy strives to provide each patient with the highest quality of care while attempting to accommodate your schedule to the best of our ability. Therefore, we provide reserved time slots for each patient in order to ensure that the appropriate amount of time is dedicated to receive the necessary course of treatment.

While we are sensitive to the fact that an emergency may occur in a rare instance, cancellations, especially last minute ones, along with patient no-shows, decrease our ability to accommodate the scheduling needs of the other patients. Additionally, no-shows display a complete lack of respect for your therapist and fellow patients. We must ask for your full cooperation with the following policy:

- A scheduled appointment MUST BE CANCELLED **AT LEAST 24 HOURS** IN ADVANCE either through an email to info@evolveptnj.com or by phone at 201.644.7585 or a $50.00 fee will be charged for that appointment. Text message replies via our automated system are NOT an acceptable means of cancellation, the messages are simply reminders.
  *Monday appointments must be canceled by Saturday at noon for a fee not to be charged.
- If you are more than 15 minutes late for your appointment and fail to notify us, treatment may be cancelled and a $50.00 fee charged for missing the appointment.
- Failure to show up for an appointment ("no-show") without notifying us or calling to cancel AFTER your scheduled appointment will result in a $75.00 fee being charged for that appointment. A second offense no-show will result in a charge of the full treatment session at our self-pay rate of $165. Furthermore, 2 consecutive, no-shows will result in the cancellation of all remaining scheduled appointments.
- All patients, regardless of insurance/third party payer, will be charged the appropriately described FEE for each late, late-cancelled, or no-show appointment. THE PATIENT IS RESPONSIBLE FOR THE FEE, NOT THE INSURANCE COMPANY/THIRD PARTY PAYER.
- All cancellations and no-shows will be documented in your medical record and appropriately reported to your physician and insurance/third party payer.
- Repeated failure to comply with this Attendance Policy will result in your name being placed on a "Schedule Based on Availability" list. This will require you to call for an open appointment on each day you would like to receive therapy. We will do everything possible to accommodate you, as space on the schedule permits.

We, at Evolve Physical Therapy, believe that this policy is necessary for the benefit of all of our patients and allows us to continue to provide high quality treatment and service to everyone. All of the staff at Evolve Physical Therapy appreciates your anticipated adherence and cooperation with this policy as we are here, as a team, to help you reach all of your goals.

I, ____ agree to provide an active credit card to Evolve Physical Therapy to maintain on file for cancellation/no show fees that are accrued.

____ ____/____/____

Patient Acknowledgement/Signature Date
Parent/Guardian Signature

Patient Financial Responsibility and Authorization Form

Thank you for choosing **Evolve Physical Therapy** for your rehabilitation needs. We appreciate that you have entrusted us with your healthcare and are committed to providing you with the highest quality of care. Please carefully read through the following form to acknowledge your understanding of our patient financial policies.

I understand and agree that I am financially responsible for all charges for any and all services rendered at the time treatment is provided.

I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance.

I understand and agree that it is my responsibility to know if my insurance has any deductible, co- payment, co-insurance, out of network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services I receive and I agree to make any payments in full.

I agree to inform the office of any changes in my insurance coverage. If my insurance coverage has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full.

If I am a Medicare patient, I understand that I need to provide the office both my Medicare ID card and my secondary ID card. If the office does not have the proper information for a secondary insurance, the secondary will not be billed. In the event that the secondary insurance cannot be billed, it will be my responsibility to pay the balance and then file a claim with the secondary insurance for reimbursement. I understand and acknowledge that there is a calendar year deductible with Medicare of $233.00 that is my responsibility to pay.

I understand and agree that if my insurance is Out Of Network with Evolve Physical Therapy, I may receive insurance checks from my insurance company for services rendered and I will forward the check/checks and EOB's (explanation of benefits) to the office within 10 days of the receipt of the check/checks. I also understand that if I do not comply, the office can charge my credit card on file for the services rendered with a 6% percent credit card processing fee.

I understand and agree that if my account is more than 30 days past due, Evolve Physical Therapy will begin assessing a 5% finance charge and administrative fees based on my balance. I understand and agree that if my account is more than 90 days past due, without an established payment plan on file, Evolve Physical Therapy will begin immediate collection actions.

I understand and agree that there will be a $30.00 NSF (non-sufficient funds) fee for any checks returned to our office because of insufficient funds. If we receive a returned check, we will notify the patient or responsible party immediately and the request that a cash payment be brought to the office within 24 hours to replace the payment amount in full.

I understand that a refund will be issued when an overpayment has been identified. If you feel a refund is due, please contact our office at 201-644-7585.

We respect patient confidentiality and only release personal health information about you in accordance with the State and Federal law. The attached notice describes our policies related to the use of records of your care and how you may get access to this information. Please review the policy carefully.

Our office does not make the rules, they are determined by your specific medical insurance plan.

By my signature below, I consent to the use and disclosure of protected health information about me for treatment, payment, and health care operations, and/or as required by law. I have the right to revoke this Consent, in writing, signed by me. However, such revocation shall not affect any disclosure already made in compliance with my prior Consent. Evolve Physical Therapy, LLC provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

______________________________	______________________________	__________
Printed Patient Name (and Guardian Name if applicable)	Patient or Guardian Signature	Date

______________________________	__________
Witness to Signature	Date