JumpStart Physical Therapy

I ACKNOWLEDGE THAT IT IS MY RESPONSIBILITY TO VERIFY AND UNDERSTAND WHAT MY CONTRACTED PHYSICAL THERAPY BENEFIT IS WITH MY HEALTH INSURANCE PROVIDER.

AUTHORIZATION TO MAKE DIRECT PAYMENT FOR MEDICAL SERVICES:
I hereby authorize that my health insurance company (ies) will be responsible for making payments directly to JumpStart Physical Therapy, Inc. for all services rendered to me.

PATIENT PAYMENT RESPONSIBILITY:
I understand that should my health plan require me to pay a co-pay per physical therapy visit, then I shall make this payment at the time the service is rendered.

I understand that I am personally responsible for paying any deductible, coinsurance, or unpaid portion of my bill directly to JumpStart Physical therapy upon request. I agree to pay an interest fee of 1.5% per month on any outstanding balance on my account.

Sick Policy: With respect to our therapists and all of our patients, please do not bring your child/yourself to the therapy appointment if they/you are in poor health.

SIBLING POLICY
For the safety of all patients and to prevent treatment interruptions we kindly ask that all siblings/children other than the patient remain in the waiting room.

CONSENT TO PHYSICAL THERAPY TREATMENT (PHYSICAL THERAPY FOR MYSELF)
I hereby authorize the staff of JumpStart to evaluate and administer physical therapy care to me.

CONSENT TO PHYSICAL THERAPY TREATMENT (OF A MINOR CHILD)
I hereby attest that I am the legal custodian of the minor child being treated for physical therapy and authorize the staff of JumpStart Physical Therapy to administer care as they deem necessary to my child.

CANCELLATION / NO SHOW POLICY:

Twenty-four (24) hour notice must be given to JumpStart to cancel an appointment. Should you cancel an appointment within 24 hours or fail to appear for a scheduled appointment without notice, a $50.00 late cancellation/no show fee will be assessed.

I have read, understand and agree to the above terms and conditions. My signature acknowledges my agreement and full understanding of the above information.

____
(Please print patient name)

Signature: ____ Date: __________________

Patient Health Record

Who is your Primary Care Physician? ____

Current Medical History

Reason for Physical Therapy: ____

Date of injury or surgical date: ____

Is this a result of a motor vehicle/work accident related? YES NO

If yes, is an attorney or liability insurance involved? YES NO

Past History

Has the patient ever been hospitalized? YES NO

If yes, please describe: ____

____

Has the patient ever had surgery? YES NO

If yes, please describe: ____

____

Medications (List all current meds including prescription, over the counter, and herbal supplements)

____

____

Allergies (Please list all allergies that the patient has)

____

____

Has the patient had or does the patient have any of the following? (Please circle all that apply)

Abnormal blood pressure
AIDS
Anemia
Arthritis
Artificial Joints
Asthma
Bleeding disorder
Bowel/Bladder Problems
Cancer
Diabetes
Epilepsy/ seizure disorder
Fainting
Fractures
Hearing problems
Heart problems
Hepatitis
Kidney problems
Liver problems
Open wounds
Osteoporosis
Pacemaker
Polio
Psychiatric Care
Respiratory disease
Stroke
Thyroid disease
Tuberculosis
Ulcers
Visual problems

Sports

Does the patient participate in sports? YES NO

If yes, what sport(s), and how often? ____

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