

TRI-STATE PHYSICAL THERAPY, INC.

DATE _____ EMAIL ADDRESS: _____

PATIENT'S NAME _____ AGE _____ SEX _____ MARITAL STATUS _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

ADDRESS _____ APT/LOT# _____ CITY _____ STATE _____ ZIP _____

SSN _____ DATE OF BIRTH _____ DRIVER'S LICENSE # _____

EMPLOYER _____ ADDRESS _____ PHONE _____

NAME OF SPOUSE _____ SSN _____ DATE OF BIRTH _____

SPOUSE'S PLACE OF EMPLOYMENT _____ ADDRESS _____ PH _____

INDIVIDUAL RESPONSIBLE FOR BILL _____ ADDRESS _____ PH _____

IS PATIENT A MINOR? YES ___ NO ___ IF YES, PARENT NAME _____ SSN _____ PH: _____

REFERRED BY: DR. _____ FAMILY/FRIEND INSURANCE WEB SEARCH OTHER _____

NAME OF INSURANCE _____ ADDRESS _____ PH _____

NAME OF INSURED _____ INSURANCE ID# _____ DOB: _____

EMERGENCY CONTACT INFORMATION (NOT LIVING AT YOUR ADDRESS). PLEASE DO NOT LEAVE BLANK.

NAME _____ RELATIONSHIP _____

PHONE _____ ADDRESS _____

DATE OF INJURY: _____ IS YOUR INJURY/SYMPTOMS DUE TO AN ACCIDENT? YES _____ NO _____

IF YES, DID THIS ACCIDENT OCCUR: AT HOME AT WORK OTHER IN AN AUTOMOBILE IN WHICH STATE _____

BRIEFLY DESCRIBE THE ACCIDENT _____

DO YOU HAVE AN ATTORNEY? (YES NO) IF YES, NAME _____ PHONE _____

MEDICAL INFORMATION

DOES YOUR MEDICAL HISTORY INCLUDE ANY OF THE FOLLOWING:

- | | YES | NO | | YES | NO | | YES | NO | | YES | NO |
|-----------------------|--------------------------|--------------------------|----------------------|--------------------------|--------------------------|-------------------------|--------------------------|--------------------------|-------------------|--------------------------|--------------------------|
| 1. ANEMIA | <input type="checkbox"/> | <input type="checkbox"/> | 7. ABNORMAL HEART | <input type="checkbox"/> | <input type="checkbox"/> | 13. METAL IMPLANTS | <input type="checkbox"/> | <input type="checkbox"/> | 19. CIRCULATION | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. DIABETES | <input type="checkbox"/> | <input type="checkbox"/> | 8. ULCERS | <input type="checkbox"/> | <input type="checkbox"/> | 14. LUNG DISEASE | <input type="checkbox"/> | <input type="checkbox"/> | 20. HEMOPHELIA | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. CORTISONE ALLERGY | <input type="checkbox"/> | <input type="checkbox"/> | 9. EPILEPSY/SEIZURES | <input type="checkbox"/> | <input type="checkbox"/> | 15. MENTAL ILLNESS | <input type="checkbox"/> | <input type="checkbox"/> | 21. BURN INJURIES | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. ANESTHETIC ALLERGY | <input type="checkbox"/> | <input type="checkbox"/> | 10. KIDNEY PROBLEMS | <input type="checkbox"/> | <input type="checkbox"/> | 16. HIGH BLOOD PRESSURE | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 5. PENICILLIN ALLERGY | <input type="checkbox"/> | <input type="checkbox"/> | 11. CANCER | <input type="checkbox"/> | <input type="checkbox"/> | 17. HEPATITIS | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 6. ARTHRITIS | <input type="checkbox"/> | <input type="checkbox"/> | 12. PREGNANCY | <input type="checkbox"/> | <input type="checkbox"/> | 18. PACE MAKER | <input type="checkbox"/> | <input type="checkbox"/> | | | |

ANY OTHER ILLNESS (PLEASE DESCRIBE): _____

LIST ANY PAST SURGERIES _____

BRIEFLY DESCRIBE YOUR SYMPTOMS: _____

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING: _____

ARE YOU ENTITLED TO MEDICARE BENEFITS? (YES NO)

IF YES, ARE YOU CURRENTLY RECEIVING ANY HOME HEALTH SERVICES? (YES ___ NO ___)

For Office Use Only
Home Health issue
discussed with patient
if Medicare?
Initials: _____

PLEASE ANSWER EACH QUESTION, AND RETURN TO RECEPTIONIST AFTER COMPLETING BACK OF FORM. PLEASE DO NOT LEAVE ANY BLANKS.

AUTHORITY TO TREAT

Permission is hereby granted to Tri-State Physical Therapy, Inc., A Professional Medical Corporation, to perform treatments of physical/occupational therapy modalities and procedures as deemed necessary by the licensed physical/occupational therapists.

AUTHORITY TO RELEASE INFORMATION

Permission is hereby granted to Tri-State Physical Therapy, Inc., A Professional Medical Corporation, for the release of my medical records to authorized representatives.

CREDIT POLICY, FEES, PAYMENTS & ASSIGNMENT OF BENEFITS

If you have health insurance, it should be understood that this is an agreement between you and your insurance company. Your therapy bill is an agreement between you and Tri-State Physical Therapy, Inc. Statements will be provided monthly, but any co-pay or co-insurance responsibility is due at the time services are rendered. You are responsible for the payment of your bill regardless of the status of your insurance claim. In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment must not be delayed due to pending insurance claims. If your insurance company does not pay within a reasonable length of time, we will look to you for payment in full.

Most insurance companies do not cover durable goods/supplies, therefore you are responsible for any durable goods/supplies you receive. Payment is required upon purchase, unless prior arrangements are made with our business office.

Charges for medical services at our clinics are billed monthly as a courtesy to our patients. We accept CASH, CHECKS, MONEY ORDERS, VISA, MASTERCARD, AMERICAN EXPRESS and DISCOVER. A minimum payment of \$50.00 is required every 30 days. If your account has been set up on a monthly payment plan and payments are not received on time or in the amount specified, a minimum rebilling fee will be assessed. The balance will also be considered delinquent and will be due and payable immediately. If unusual circumstances should make it impossible for you to meet our credit terms, we invite you to call or personally discuss the matter with our credit department. Except when hardship warrants otherwise, accounts 90 days past due will be referred to our collection agency or attorney for further action. If you are involved in a liability claim, representation by an attorney does not constitute payment for services. We will be happy to provide your attorney and/or insurance carrier with an itemized statement for your reimbursement. Due to the length of time these cases take for settlement, it is both unrealistic and very costly for us to wait for payment upon settlement.

I will be responsible for payment of the total bill incurred as a result of treatment received. Although I may choose to use insurance coverage to pay all or any portion of the bill incurred, I understand that the filing of insurance forms does not constitute payment of any portion of the bill and I understand that I am responsible for all charges billed to me for treatment of the above patient. I accept full responsibility for payment of the total balance of my account. **I understand I will be responsible for all collection costs, attorney fees and court costs if my account becomes delinquent.**

I have this date assigned to Tri-State Physical Therapy, A Professional Medical Corporation, the benefits due under my existing policy or policies of insurance. I understand in so far as they are necessary to cover such expenses, that the above assignment of insurance is accepted by Tri-State Physical Therapy, A Professional Medical Corporation, as a convenience to me and said corporation is hereby given my consent to file claims on said policy and to do such other actions as it deems necessary in connection therewith so as to promptly obtain payment under the said policy. I direct my insurance company to pay Tri-State Physical Therapy, A Professional Medical Corporation, directly, without payment to me. I authorize my attorney to pay Tri-State Physical Therapy, Inc. directly from any settlement proceeds

MEDICARE POLICY

I certify that the information given by me in applying for payment under Title IVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf to Tri-State Physical Therapy, Inc. I agree to pay all deductibles and co-insurance amounts not reimbursed by my insurance policies.

I, the undersigned, have read and understood the above Authority to Treat, Authority to Release Information, Credit Policy & Assignment of Benefits and Medicare Policy. I hereby agree to the terms therein.

Date: _____ Patient: _____

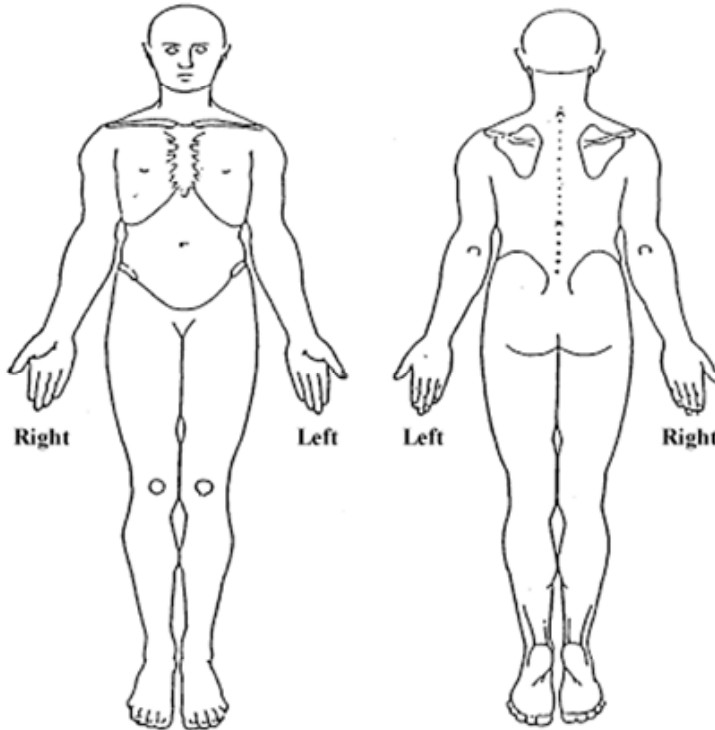
Witness: _____ Responsible Party: _____

Pain and Symptom Status Report

Name: _____

Date: _____

Indicate on the body chart below where your pain is located at the present time



- | | | | |
|------------------|----------------------|------------------------|-----------------|
| _____ Aching | _____ Throbbing | _____ Burning | _____ Spasmodic |
| _____ Periodic | _____ Dull | _____ Sharp | _____ Radiating |
| _____ Stabbing | _____ Numbness | _____ Soreness | _____ Tingling |
| _____ Discomfort | _____ After Activity | _____ Pins and Needles | _____ |

Chief Complaint and Visual Analog Scale

My Chief Complaint is: _____

Date First Symptom of your problem occurred on: _____

2nd Complaint: _____

3rd Complaint: _____

Please circle on the scale below to indicate your **CURRENT** level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it gets.

Please circle on the scale below to indicate your **AVERAGE** level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it gets.

Please circle on the scale below to indicate your **WORST** level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it gets.

Additional Comments _____