DANIEL B NEFF, DPT PHYSICAL THERAPY

PATIENT NAME: _____ BIRTHDATE: _____

AUTHORIZED PERSON (IF PATIENT IS A MINOR) _____ BIRTHDATE: _____

FULL ADDRESS: _____CITY_____ ST_____ZIP_____ PHONE: _____

EMAIL: _____ PHYSICIAN: _____

CONSENT FOR TREATMENT

During the course of treatment, you may experience an increase in your symptoms. In most circumstances this is a normal part of the recovery process. It is important for you to inform the clinical staff of any difficulties that you are experiencing. You may contact this facility at any time to discuss your status. If you believe that what you are experiencing is out of ordinary, please contact your physician. Please remember that your care is our top priority. We want to provide you with as much information and education that we can to help expedite your recovery. In the case of a minor patient (under the age of 18) I hereby authorize Daniel B. Neff, DPT Physical Therapy to administer physical therapy care deemed necessary for the course of treatment when I am unable to accompany my son/daughter for treatment. I understand the risks involved in physical therapy and agree to fully cooperate and to participate in all physical therapy procedures and to comply with the established plan of care.

FINANCIAL POLICY

We will gladly try to answer any questions related to your insurance but insurance plans vary considerably and we cannot predict or guarantee what will or will not be covered by your insurance. Your insurance is a contract between you and your insurance company as well as your employer if employed. We are not a part of that contract and do not have knowledge of the physical therapy benefits that are contract in your insurance policy. We must emphasize that as a physical therapy practice our relationship is with you and not the insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all services are strictly your financial responsibility from the date of service rendered. Therefore, it is often necessary for you to inquire and explore your benefits with your insurance carrier. Any patient responsibility costs given to you by your insurance company will become your responsibility. Monies will be collected at time of serve for estimated co-pays, deductibles and co-insurance. Refunds will be issued, if warranted, after all EOB's are received from your insurance. We realize that temporary financial problems may affect timely payment of your account. We now have several options to select for your payment options. Please see below and select payment option: Our office is fully approved and accredited user of Visa and Mastercard Health Care program.

Daniel B. Neff, DBT Physical Therapy will occasionally send out, via email or mail, information to you concerning upcoming workshops/newsletters and other clinical updates. Please indicate to us if you would prefer your address/email address not be included in the mailing by initialing beside this paragraph _____

Please sign and date below that you have read and understand this document. This consent and financial policy will expire after one year of the signature date or unless otherwise specified by the patient.

Signature: _____ Date: _____

NEFF PHYSICAL THERAPY

Medical History

Patient Name: _____ DOB: _____ Date: _____

Are you currently experiencing or have you had any of the following?

High Blood Pressure	Y	N	Heart Disease	Y	N	Numbness	Y	N
Shortness of Breath	Y	N	Pacemaker	Y	N	Cancer	Y	N
Female Problems	Y	N	Weakness	Y	N	Pregnant	Y	N
Night Pain	Y	N	Diabetes	Y	N	Dizziness	Y	N
Irregular Heart Rate	Y	N	Fatigue	Y	N	Osteoporosis	Y	N
Headaches	Y	N	Stroke	Y	N			

Height: _____ Weight: _____ Have you fallen in the past year? Y N

Medications: _____

Medical History: _____

Surgeries? Y N (List) _____

How would you rate your general health? (Circle one) Poor Fair Good Excellent

In the past 3 months, have you experienced any significant changes in health (physical or mental) List:

_____

What is your current complaint? _____ When did is start? _____

Due to an injury? Y N (Explain) _____Illness? _____

Did the symptoms begin: Suddenly or Gradually Previous problems in this area? Y N

Previous therapy for this condition? Y N What effect? _____

Have you had chiropractic or any other treatment for condition? Y N

Does your pain radiate? Y N Where? _____

What reduces your pain? _____

Recent tests: X-ray CT MRI EMG Myelogram Other _____

Results: _____

Did the physician put you on any restrictions? Y N List: _____

Based upon a 0 to 10 scale (0 is none and 10 is severe), what is your pain?

Right now: _____ Highest pain in the past 24 hours: _____ Lowest pain in the past 24 hours: _____