BELIEVE • COMMIT • ACHIEVE

Dear New Patient,

The staff at CrossRoads Physical Therapy and I are delighted that you have chosen our facility for your therapy. Our goal is to provide you with a premium level or care and a beneficial experience. If at any point, you have questions or concerns regarding any aspect of your treatment, please feel free to immediately call or contact me via email at Kevin@crphysicaltherapy.com.

Thank you again for choosing CrossRoads for your care. We hope to exceed your expectations.

Sincerely,

Kevin Perris

Kevin Perris, DPT, MS, PT, Cert. MDT
Physical Therapist & Owner

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Patient Information

Name: _____ Cell Phone: _____

Street Address: _____ Home Phone: _____

City: _____ State: _____ Zip:_____

Employer: _____ Work Phone: _____

Sex: ☐ Male ☐ Female Height: _____ Weight: _____

Social Security #:_____ Date of Birth: _____/_____/_____

Spouse/Emergency Contact Name: _____ Contact Phone: _____

Primary Care or Referring Physician: _____

Check here to receive appointment reminders via text message: ☐

Email Address: _____

How did you hear about us? (Please be specific)

☐ Search Engine/Website
☐ Social Media _____
☐ Existing Patient
Name _____
☐ Insurance Company
☐ Doctor/Physician_____
☐ Mailer
☐ Other _____

Insurance Information

Primary Insurance: _____ Subscriber's Name: _____

ID#: _____ Group #: _____ Effective Date: _____

Secondary Insurance: _____ Subscriber's Name: _____

ID#: _____ Group #: _____ Effective Date: _____

Current Condition

Reason for today's visit? _____

When did your symptoms begin? _____

Rate the severity of your pain on a scale of 0 (no pain) to 10 (severe pain) 0 1 2 3 4 5 6 7 8 9 10

What type of pain are you experiencing? (Circle all that apply)

Sharp Dull Throbbing Tingling Stiffness Numbness Shooting Aching Burning

Does your pain radiate from one area to another? Yes No If yes, please explain:

_____

Have you had this pain before? Yes No Have you received treatment for this before? Yes No

If yes, what did the previous treatment consist of (medications, surgery, etc)?_____

_____

Health History

Please list any previous surgeries, fractures or breaks, falls, head injuries, or other illnesses you have had:

Date	Type of surgery/injury/illness	Date	Type of surgery/injury/illness

Medications

Please list all medications you are currently taking (prescription and over the counter) and bring a list of all medications with you to your appointment.

Name of Medication	Dosage	Route of Administration	How many times a day

HEALTH HISTORY CONTINUED

Please check YES or NO to indicate if you have ever had any of the following:

Name of Condition	YES	NO	Name of Condition	YES	NO
Aids/HIV			Kidney Disease		
Alcoholism			Liver Disease		
Anemia			Measles		
Anorexia			Migraine		
Appendicitis			Miscarriage		
Arthritis			Mononucleosis		
Asthma			Multiple Sclerosis		
Bleeding			Mumps		
Breast Lump			Osteoporosis		
Bronchitis			Pacemaker		
Bulimia			Parkinson's		
Cancer			Pinched Nerve		
Cataracts			Pneumonia		
Chemical Dependency			Polio		
Chicken Pox			Prostate Problem		
Diabetes			Prosthesis		
Emphysema			Psychiatric Care		
Epilepsy			Rheumatoid		
Fractures			Rheumatic Fever		
Glaucoma			Scarlet Fever		
Goiter			Stroke		
Gonorrhea			Suicide Attempt		
Gout			Thyroid Problems		
Heart Disease			Tonsilitis		
Hepatitis			Tumors, Growths		
Hernia			Typhoid Fever		
Herniated Disk			Ulcers		
Herpes			Vaginal Infections		
High Cholesterol			Venereal Disease		
High Blood Pressure			Whooping Cough		

Please list anything OTHER: _____

To help us understand your symptoms, please circle all that apply.

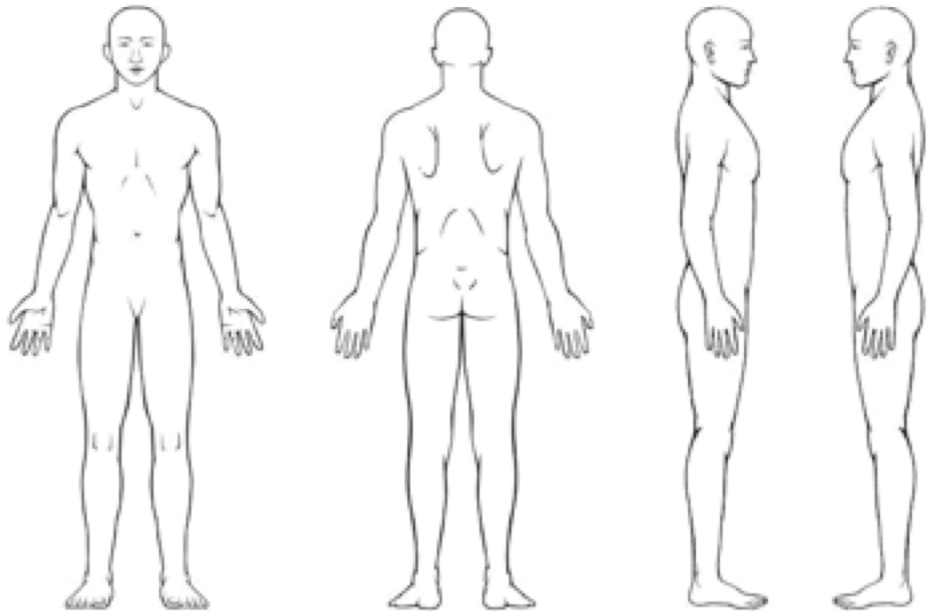
My pain is worse: in the morning/ during the day/ at night/ constant/ with activity/ during rest

On a scale of 0 to 10 (0 being no pain and 10 being unbearable pain requiring hospitalization)

Please rate your pain at its best _____ and at its worst_____

Pain Diagram

Using the key provided, please draw the symbol representing your pain over the area of the body as it relates to your present condition



Key

↑ or ↓ Radiating Pain

XXX Spasm

ZZZ Tenderness

//// Numbness/Tingling

000 Ache/Pain

Is there any other information regarding your medical history that we should know about? _____

_____

What is your goal for therapy at this time? _____

_____

Signature of Patient or Guardian (if patient is a minor): _____ Date: _____

Signature of Clinician: _____ Date: _____

Payment Policy

1. Insurance: We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. **If your insurance coverage changes, please notify us before your next visit** so we can make the appropriate changes to help you receive your maximum benefits. **You are fully responsible for understanding your insurance policy and coverage.**

2. Referrals: If your insurance requires a referral for a specialist, it is your responsibility to provide us with the referral dated the day of your first visit from your Primary Care Physician (PCP). We are not able to request a referral from your PCP or insurance. If you do not have the referral at the time of your visit, your appointment will be rescheduled until we have the referral. If you are unsure if you require a referral or have any other questions concerning your insurance, we suggest you contact your insurance company. **Knowing your insurance benefits is your responsibility.**

3. Co-Payments and Deductibles: All co-payments and deductibles must be paid **at the time of service.** This arrangement is part of your contract with your insurance company. Failure on our part to collect copayments and deductibles from patients can be considered fraud.

4. Claims Submission: We will submit your claims and assist you in any way we reasonably can to help get your claim paid. If your insurance company needs you to supply certain information directly, it is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance pays your claim. **If your insurance company does not pay your claim within 60 days, the balance will be automatically billed to you.** Your insurance benefits are a contract between you and your insurance company; we are not party to that contract.

5. Collections: Unpaid balances will be sent to collections. If your balance is sent to collections, you will be responsible for 33% of your balance in addition to the original amount sent to collections.

Assignment of Benefits Authorization

I certify that I, and/or my dependent(s), have insurance coverage with _____ *(insurance company). I assign directly to CrossRoads Physical Therapy, PC all insurance benefits, if any, otherwise payable to me for services rendered.* ***I understand that I am financially responsible for all charges whether or not paid by insurance.*** *I authorize the use of my signature on all insurance submissions. I also authorize release of medical information relevant to these services when required by Health Care Financing Administration (HCFA), its agents, or insurance carriers for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.*

Notice of Privacy Practices

I acknowledge that I have been given CrossRoads Physical Therapy's Notice of Privacy Practices. I understand that if I have any questions or complaints, I may contact the facility.

Missed, Cancelled, Late & Rescheduled Appointments Policy

Patients will be charged $25 for missed appointments and for appointments **cancelled within the 24 hours preceding the appointment**. This means if the patient calls the day of his/her appointment to cancel, there will be a $25 fee enforced. For any patients who show up 15 minutes late to his/her appointment the appointment may have to be rescheduled and the $25 fee may be enforced. We need at least 24 hours' notice to be able to fill **any** open appointments from patient cancellations. The charges will be your responsibility and must be paid on your next visit.

Appointment Reminders

Appointment reminders will be sent out via text message two days prior to the appointment. If patient does not wish to receive a text, we will not be able to send out a reminder. If you prefer a voicemail reminder, please inform front Office Staff.

Consent to Treat

Patient's Name: _____

I have been informed of the nature of my disorder(s) and of the nature and purpose of Physical Therapy procedures proposed as treatment. I have also been informed of the possible consequences and risks inherent in such treatment. The availability of alternate treatment options has been explained to me. I have also been advised of the possible consequences if I decide not to receive care. I understand that there is no guarantee or warranty for any specific cure or result.
The welcome package / information package and all data from CrossRoads Physical Therapy may be used for health, information, and billing purposes interchangeably between these different office locations if necessary.

I have read the above statements and I understand the information provided. I therefore authorize this clinic to proceed with Physical Therapy care and treatment.

Patient's Signature: _____ Date: _____

Please complete the following if the patient is *a minor or unable to consent.*

Name of person legally authorized to sign for this patient: _____

Relationship to patient: _____

Signature of authorized person: _____ Date: _____