"Where dedicated, personalized care is at the core of your experience."

Outpatient Information Form

Date _____

PATIENT INFORMATION

Patient Name _____Middle Initial_____

Phone Number_____ Cell Phone _____

Work Number_____

Address_____ City_____

State _____ Zip Code_____

DOB _____ Social Security # _____

Email (optional)_____

Sex M□ F□ Marital Status M □ S□ W□

How did you hear about TheraCORE Physical Therapy?_____

EMPLOYMENT INFORMATION

Employer_____ Occupation _____

Address _____

City, State, Zip _____

INJURY INFORMATION

Referring Physician_____

Diagnosis_____

Date of Injury _____

Work Injury? Yes No Car Accident? Yes No Law Suit Pending? Yes No

INSURANCE INFORMATION

Please be sure to let us make a copy of your insurance card.

If your insurance information changes at any point during your treatment at TheraCORE, please be sure to get us an updated copy of your insurance information.

Insurances and Worker's Compensation companies are billed daily. Once all of your insurances have been billed, and we have gotten an explanation of benefits and payment from your insurance, we will invoice you the portion of your treatment fees that are your responsibility. We invoice patients one time monthly (at the beginning of the month). You will only be invoiced for your visits that have been paid by insurance.

If you are a self-pay patient, payment will be expected at the time of your treatment, unless other arrangements have been made.

Patients with a high, outstanding deductible ($2000.00 or greater) will be expected to pay a $60.00 charge at each treatment session, until the deductible has been met. This amount will be applied towards their monthly statement. Our office managers can check with your insurance company for an update on a deductible balance upon request.

_____

Initial

CANCELLATION POLICY

We value our patients' time. Please help us by being courteous and calling at least 24 hours in advance if you need to reschedule or cancel an appointment.

There will be a $30.00 charge for each appointment that is cancelled with less than 24 hours notice. (This charge is not covered by any insurance).

The cancellation charge will be assessed to your regular invoice statement. We thank you, in advance, for your adherence to our attendance policy.

_____

Initial

MEDICAL INFORMATION

List past SURGERIES and/or INJURIES: _____

_____

_____

List **ALL** current medical conditions (i.e. High Blood Pressure, Diabetes, Depression): _____

_____

_____

List **ALL** prescription medications, over the counter medications and/or supplements you are currently taking including strength, does and route the medication is administered:

_____

_____

_____

_____

_____

_____

TheraCORE offers **nutritional counseling** with a registered dietitian. You may want to consider scheduling an appointment if you can answer yes to any of the following questions:

1. Are you unhappy with your weight? Yes / No
2. Would you be interested in talking to our staff Dietician about a healthy eating plan? Yes / No
3. Are you pregnant or nursing? Yes / No
4. Do you have any medical conditions such as Diabetes, High Blood Pressure, or Heart Problems? Yes / No
5. Are you an athlete that would like to improve your performance? Yes / No

EMERGENCY CONTACT INFORMATION

Please list a person that TheraCORE can contact in case of an emergency:

Name_____ Relationship to patient _____

Phone number _____

AUTHORIZATION FOR TREATMENT

Your signature below is required to authorize treatment. Your signature also authorizes the release of medical information needed to process your claim, allowing an assignment of benefits where a claim has been filed. An additional signature is required by a parent/legal guardian for all minors.

Patient Signature _____ Date _____

Parent /Guardian Signature _____ Date _____