TheraCORE Physical Therapy

Outpatient Information Form

Date _____

PATIENT INFORMATION

Patient Name _____Middle Initial_____

Home Phone Number_____ Cell Phone _____

Address_____ City_____

State _____ Zip Code_____ Sex M□ F□

DOB _____ Social Security # _____

Email _____

Would you like reminders about your appointments? Y or N Email or Text

Employer_____ Occupation _____

How did you hear about TheraCORE Physical Therapy?_____

INJURY INFORMATION

Physician we should communicate with _____

Diagnosis_____ Date of Injury _____

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

EMERGENCY CONTACT INFORMATION

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

Name_____ Relationship to patient _____

Phone number _____

GOALS

Please write down three goals or outcomes you wish to achieve with the help of your physical therapist. (ie: no pain with running, be able to turn head while driving, walk up a flight of stairs)

1._____

2._____

3._____

MEDICAL INFORMATION

List ALL Orthopedic Injuries:

Injury	Date	Surgery	Other Treatments

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

Condition	Date Diagnosed	Surgery	Other Treatments

List ALL prescription medications, over the counter medications and/or supplements you are currently taking:

Medication	Dosage	Times per Day	Reason

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.

_____
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

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 _____