

TheraCORE

PHYSICAL THERAPY | FITNESS

Outpatient Information Form

Date _____

PATIENT INFORMATION

Patient Name _____ DOB _____

Main Phone Number _____ Secondary Phone Number _____

Address _____ City _____

State _____ Zip Code _____ Sex M F

Email _____

Would you like text reminders about your appointments? Y or N

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.
(i.e. 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 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 taking

Medication	Dosage	Times per day	Reason

INSURANCE AND PAYMENT 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.

Insurance and Worker’s Compensation companies are billed daily. Once all your insurances have been billed, and we have an explanation of benefits and payment from your insurance, we will invoice you for the portion of treatment fees that are your responsibility. We invoice patients weekly. 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 deductible will be expected to pay amount quoted on VOB at each treatment session, until the deductible has been met. This amount will be applied towards their statement. Our office managers can check with your insurance company for an update on a deductible balance upon request.

Co-payments are due at time of treatment session.

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 \$35.00 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 invoice. 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 _____