

**Active Life & Sports**  
**Patient Information Form**  
**Please Print**

Patient Name: \_\_\_\_\_

Address/City/State: \_\_\_\_\_ Zip \_\_\_\_\_

Phone: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Patient's Social Security #: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

INSURANCE #1: \_\_\_\_\_

Insured Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Policy is Through: \_\_\_\_\_  
(Employer or Self)

INSURANCE #2: \_\_\_\_\_

Insured Name: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Date of Birth \_\_\_\_\_ Policy is Through: \_\_\_\_\_  
(Employer or Self)

Referring Physician Name: \_\_\_\_\_

Primary Care Physician Name: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

INJURY/DIAGNOSIS: \_\_\_\_\_

Are your injuries the result of an auto accident? Yes or No If yes, when did the accident occur?  
Date \_\_\_\_\_ What state did the accident occur? \_\_\_\_\_

Are your injuries work related? Yes or No If yes, when did your injuries occur? \_\_\_\_\_

If not auto or work related when did your injury/surgery occur? \_\_\_\_\_

I agree to receive or give permission for myself or the above-named minor to receive Physical Therapy services appropriate for this condition. I authorize the release of any information necessary for care and to process insurance claims. I authorize direct payments to be made to **Active Life & Sports Physical Therapy** for physical therapy services and I understand that I am responsible for any amount not covered by my insurance company. I have read and understand the Active Life & Sports Physical Therapy privacy policy.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

## MEDICAL SCREENING FORM

Name: \_\_\_\_\_  
Sex:    M    F Age: \_\_\_\_\_  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Circle YES or NO...

Have you ever been told you have:

Cancer? Yes... No  
Diabetes? Yes... No  
High blood pressure? Yes... No  
Heart disease? Yes... No  
Angina/chest pain? Yes... No  
Stroke? Yes... No  
Osteoporosis? Yes... No  
Osteoarthritis? Yes... No  
Rheumatoid arthritis? Yes... No

Do you have a history of:

Allergies/Asthma? Yes... No  
Headaches? Yes... No  
Bronchitis? Yes... No  
Kidney disease? Yes... No  
Rheumatic fever? Yes... No  
Ulcers? Yes... No  
Sexually transmitted disease? Yes... No  
Seizures? Yes... No

In the past 3 months have you had or do you experience:

A change in YOUR health? Yes... No  
Nausea/Vomiting Yes... No  
Fever/chills/sweats? Yes... No  
Unexplained weight change? Yes... No  
Numbness or tingling? Yes... No  
Changes in appetite? Yes... No  
Difficulty swallowing? Yes... No  
Changes in bowel or bladder function? Yes... No  
Shortness of breath? Yes... No  
Dizziness? Yes... No  
Upper respiratory infection? Yes... No  
Urinary tract infection? Yes... No

Please List your current medications:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What is your primary reason for coming to Physical Therapy? \_\_\_\_\_

\_\_\_\_\_

Are you scheduled to return to the doctor who referred you to Physical Therapy? If so, when? \_\_\_\_\_

Please list any diagnostic tests regarding your current injuries (MRI, Xray, EMG, CAT scan) \_\_\_\_\_

\_\_\_\_\_

Please indicate the degree to which your condition limits you from performing the following activities:

0= no limitation 10=completely limited

___ Dressing	___ Sleeping
___ Toileting	___ Hobbies
___ Driving	___ Stairs
___ Bathing	___ Job duties
___ Exercise/Sports	___ House chores
___ Meal preparation	___ Other: _____

Are you currently:

Pregnant? Yes... No  
Depressed? Yes... No  
Under stress? Yes... No  
Smoking? Yes... No  
If yes: \_\_\_ packs x \_\_\_ years

Are your symptoms: (check one)

Getting Worse  The Same  Improving

Do you have a problem with?

Hearing  Speech  Vision

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Reviewed by: \_\_\_\_\_

## PAYMENT POLICY AND PROCEDURES

\*\*\*\*\*There will be a \$20.00 charge for any returned checks\*\*\*\*\*

### INSURANCE INFORMATION

As a courtesy to our patients, we will verify and file your insurance claim; however, we cannot guarantee payment. We strongly suggest that you read your policy manual as it pertains to physical therapy coverage. Many insurance companies have stipulations, such as usual and customary fees (UCR), limited therapy sessions, limit reimbursable amounts per session, deductibles, co-payments, limits on supplies, etc. Such stipulations should be indicated in your policy manual.

**YOU ARE RESPONSIBLE FOR AMOUNTS NOT COVERED BY YOUR INSURANCE.**  
We have an agreement with YOU, not your insurance company, for receipt of payment. Please be aware of this and plan to make payments accordingly.

Workers compensation benefits will be verified; however, this does not guarantee payment. In the event of denial, this account will become **YOUR RESPONSIBILITY**.

### CONSENT TO TREATMENT

I understand that I have been referred for rehabilitative treatment and care to **Active Life and Sports Physical Therapy**. **Active Life and Sports Physical Therapy** has described for me my individual treatment plan. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including any risks or alternative treatment plan that has been prescribed by my physician and or recommended by my therapist. By signing this agreement, I consent to have **Active Life and Sports Physical Therapy** provide treatment and care as prescribed by my physician and/or recommended by my therapist.

### ASSIGNMENT OF PAYMENT

I understand, fully, the payment and billing procedures of **Active Life and Sports Physical Therapy**. I hereby authorize **Active Life and Sports Physical Therapy** to furnish my insurance company(s), attorney, or legal representative all information that said parties may request concerning my present illness or injury. I hereby assign **Active Life and Sports Physical Therapy** all money to which I am entitled for medical expenses related to the services reported here, but not to exceed my indebtedness to **Active Life and Sports Physical Therapy**. It is understood that any money received from the above named parties over and above my indebtedness will be refunded to me when my bill is paid in full. I understand that I am financially responsible to **Active Life and Sports Physical Therapy** for charges not covered by my insurance company. I agree to pay interest at the rate of 1.5% per month on any unpaid balance owed on my account, and further agree to pay attorney fees equal to 30% of the total amount due, should my account be referred to an attorney for collection. I certify by my signature that I have read and agree to this information.

Please mail all payments to: **ACTIVE LIFE AND SPORTS PHYSICAL THERAPY**  
4337 Ebenezer Road  
Perry Hall, Maryland 21236

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Printed Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

## CANCELLATION/NO SHOW POLICY AGREEMENT

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

It is our desire at **Active Life and Sports Physical Therapy** to provide each patient with the highest quality of services in the most expeditious manner. Therefore, we provide a reserved time slot for each patient so that there is minimal waiting and each person receives individual attention.

In order for us to continue with this service, we ask that you **call at least 24 hours in advance** if you are unable to keep your scheduled appointment. Missed appointments without notification will result in a **\$40.00** no show charge. **Furthermore, additional visits that you have scheduled will be automatically canceled.**

Additionally, three (3) missed appointments during the course of your treatment will require us to discharge you from physical therapy and inform your physician, case manager, and/or insurance carrier of our discharge status. We understand that personal schedules can be hectic, but in order to accommodate the needs of all our patients, we must maintain some level of accountability. As well, missed appointments on your part do not allow for continuity of care and affects your ability to reach the goals as outlined by you and your physical therapist.

We appreciate the opportunity to provide your rehabilitation care. Thank you for your consideration of our staff and other patients who may need your appointment time.

I have reviewed and agree to comply with the above cancellation policy.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE