COMPLETE PHYSICAL THERAPY
CENTERS OF GEORGIA

PATIENT INFORMATION

Title **First Name** **MI** **Last Name**

Address **Apt#** **City** **State** **Zip Code** **County**

Home Ph. ( ) **Work Ph. ( )** **Social Security #**

Date of Birth Age Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Widowed

Spouse's Name Home Ph. ( ) Work Ph. ( )

Patient's Employer **Patient's Occupation**

Employer Address **City** **State** **Zip Code**

Emergency Contact not living with you Home Ph. ( ) Work Ph. ( )

Emergency Contact Address City State Zip Code

RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

First Name MI Last Name

Address City State Zip Code

Work Ph. ( ) Date of Birth Social Security #

Employer Address City State Zip Code

INSURANCE INFORMATION

Primary Insurance Company Phone ( ) Effective Date

Address City State Zip Code

Policy Holder's Name DOB SSN

ID # Group #

Secondary Insurance Company Phone ( ) Effective Date

Address City State Zip Code

Policy Holder's Name DOB SSN

ID # Group #

How did you learn about the Ankle and Foot Center? ☐ I saw your sign. ☐ I was referred by Dr. _____

☐ A friend or another patient referred me. ☐ Yellow Pages ☐ Promotional Coupon ☐ Other: _____

It is the policy of our office that all fees are due at the time services are rendered whether by check, cash or credit card unless prior arrangements have been made. We welcome frank discussion of services and fees at the time of treatment in order to avoid any misunderstandings.
We are happy to file your insurance for you, however, regardless of insurance coverage; you are responsible for payment of your account within the credit policy of this office. If fees are incurred in order to collect delinquent accounts, those fees will be the responsibility of the patient.

I authorize the release of any medical/surgical information necessary to process this claim and authorize payment of medical/surgical/medical equipment benefits to be made directly to Ankle and Foot Centers of Georgia/ Complete Physical Therapy Centers of Georgia/and or International Center for Foot and Ankle Surgery. After all insurance payments have been paid I fully understand that I am responsible for the remaining balance of my account.

Signature of Patient or Responsible Party: _____ Date: _____

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PATIENT CONSENT FORM

NAME: _____ DOB: _____ CHART#:_____

HAVE YOU HAD PHYSICAL/ OCCUPATIONAL/ OR SPEECH THERAPY THIS CALENDAR YEAR? _____ (PLEASE CIRCLE WHICH ONE ABOVE)

INSURANCE: We will file your claims; however, the services are rendered and charged to you. This is your responsibility and obligation. All co-pays are due at the time of each visit, unless otherwise arranged with our office staff. We will verify that you have benefits for Physical Therapy, but this is not a guarantee of payment from them. We will attempt to get any referrals from your Insurance Company if necessary, but it is your responsibility to make sure they are received.

CONSENT TO TREAT: I CONSENT TO REHABILITATION AND THE INCIDENTAL MEDICAL SERVICES AT PHYSICAL THERAPY CENTERS OF GEORGIA.

I allow Complete Physical Therapy Centers of Georgia to give information related to me to any third party payer, insurance company, or parties hired by these payers which may be responsible in whole or part for paying my bill, to monitor utilization of rehabilitation services, or to any healthcare facility or physician in which I am referred. I hereby assign all benefits directly to Complete Physical Therapy Centers of Georgia and also authorize release of medical records to process medical claims.

_____ _____

Signature of Patient or Guardian Date

_____ _____

Signature of Office Staff/Witness Date

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COMPLETE PHYSICAL THERAPY
CENTERS OF GEORGIA

To ensure your privacy, please answer the following questions and notify the Front Office Staff whenever this information change.

1. Do we have permission to leave a message on the phone number(s) you have provided to us?

   YES ☐ OR NO ☐

2. May we discuss your Medical Information with family and friends?

   YES ☐ OR NO ☐

Please list names of people we can discuss your medical care with:

Name: _____ Phone #: _____

Pt's Relationship to contact: ☐ Spouse ☐ Parent ☐ Child ☐ Friend

Name: _____ Phone #: _____

Pt's Relationship to contact: ☐ Spouse ☐ Parent ☐ Child ☐ Friend

Name: _____ Phone #: _____

Pt's Relationship to contact: ☐ Spouse ☐ Parent ☐ Child ☐ Friend

3. If someone calls for you or asks for you while you are in our office, do we have permission to tell them you are here?

   YES ☐ OR NO ☐

_____ _____
Patient Signature Original Date

_____
Patient Name (Printed)

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PAIN QUESTIONNAIRE

Name _____ Date _____

Occupation _____ Presently working___

Age _____ Height _____ Weight _____

Chief Complaint:_____

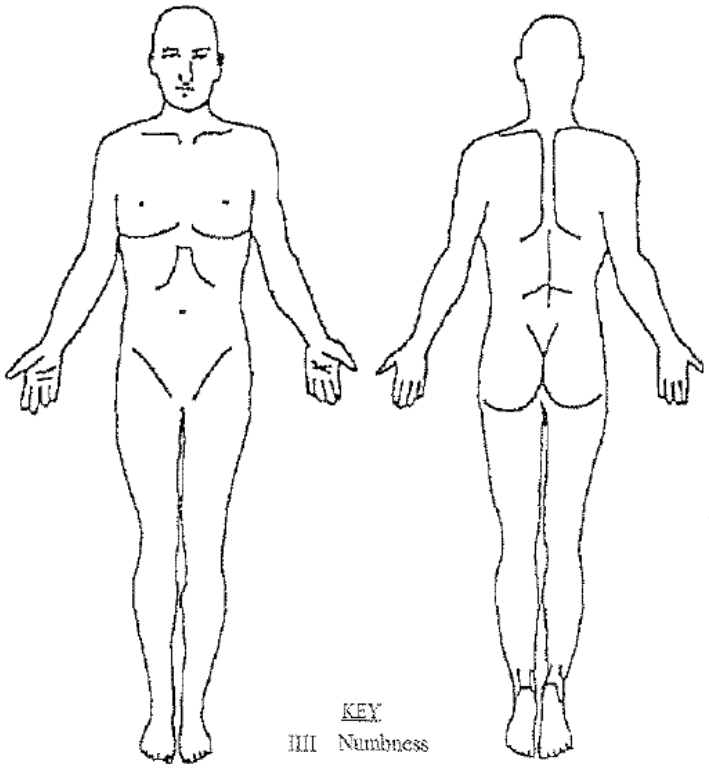
When did the present symptoms start? _____

Cause: _____

_____

Was the onset gradual or a result of an injury or accident? _____

Where is the pain now? (mark diagram)



Describe symptoms: (check if applicable)

___constant ___throbbing ___burning ___dull

___numbness ___tingling ___intermittent ___sharp

Depth of Symptoms: ___Deep ___Superficial ___none

Swelling? __Yes __No If yes, frequency _____

Instability? __Yes __No If yes, frequency _____

Do you have any loss of sensation? _____

What activities/positions increase pain? _____

_____

What activities/positions decrease pain? _____

_____

Can you get comfortable at night? _____

How do you feel in the morning? ___stiff ___sore ___fine ___other

How is your pain at the end of the day? ___ worse ___better

Have you had a similar problem before? ___Yes ___No If yes, how long ago? _____

How long did this problem persist? _____

Have you ever had physical therapy for this problem? ___Yes ___No If yes, what type of treatment did you receive?_____

_____

What medical help have you sought for this problem? __ Doctor __ Chiropractor __ Physical Therapist

What medications are you presently taking? _____

What allergies do you have? _____

Do you have a pacemaker? ___Yes ___No Are you pregnant ___Yes ___No

Have you had any X-rays to diagnose your symptoms? _Yes _No If yes, when? _____

Have you had any other tests performed? _____

Regular exercise program? ___Yes ___ No If yes, frequency and type _____

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Payment

It is our policy to collect all co-pays, coinsurances, deductibles, and balances at time of service. For payment arrangements please speak with our billing office.

Scheduled Appointments

We understand that unplanned issues may arise and you may not be able to make it to your appointment on time. If that happens, we respectfully ask that you notify our office. If you arrive after your scheduled time, you may be asked to wait for a break in the schedule or reschedule for a later time or date.

Thank you for being a valued patient and for your understanding and cooperation.

I, _____ have read and understand this policy.
Print Name

_____ _____
Signature Date

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COMPLETE PHYSICAL THERAPY
CENTERS OF GEORGIA

CANCELLATION and NO SHOW POLICY:

Our physical therapists and staff work very hard to meet the needs of our valued patients while providing a range of available times to receive treatment. To ensure you and all of our patients have access to convenient, quality care, please notify us at least 24 hours in advance if you need to cancel your appointment.

If you are not able to keep your scheduled appointment time and you do not give us a 24-hour notice, you will be charged a $35.00 missed appointment fee.

**Please note that the $35.00 fee is not covered by your insurance and does not apply to your deductible or out-of-pocket maximum. Fees are applied fifteen minutes after your scheduled appointment time.*

_____ _____

Patient Signature Date

Stop. This packet is complete. Thank you.