touchstone
Physical Therapy & Wellness

Who may we thank, for referring you to us_____

General Information	Injury is work related? Y / N from auto accident: Y / N Bill to Patient ___ Health Ins____ Work Comp____ Auto Ins_____
Patient Name: Mr. Mrs. Ms. Dr.	
Last Name: Initial:	**Primary Health Insurance**
First Name:	Name:
Address:	Phone Number:
	Policyholder:
City:	Relationship:
State: Zip:	Policy # Group#
Home Phone:	Policyholder's DOB / /
Work Phone:	Employer:
Cell Phone:	**Secondary Insurance**
Email:	Name:
Social Security #:	Phone Number:
Date of Birth / / Sex: M / F	Policyholder:
Employer:	Relationship:
Occupation:	Policy #: Group #:
Reason for Visit	Policyholder's DOB / /
Complaint:	Employer:
	Workers Comp / Auto / PIP/ Other
Date of onset:	Carrier Name:
Surgery (Y/N) Date:	Claim/ S.S #
Notes:	Carrier Phone #
Previous Physical Therapy: Y / N	Adjuster name:
Date of last PT visit:	Adjuster Phone #:
Referring Physician	Lawyer's name:
Name:	Lawyer's number:
Phone #:	**Responsible Party**
Primary Care Physician	Name:
Name:	Address:
Phone #	Relationship:
Emergency Contact	Home phone #:
Name:	Alternate phone #:
Relationship:	For Office Use Only
Home phone #:	Staff completing:
Work phone #:	Entered WebPT: Y/N Date: Time:
Cell phone #:	
Best method to confirm appt: Home phone ☐ Cell phone ☐ Work phone ☐ Email ☐	

touchstone
Physical Therapy & Wellness

MEDICAL HISTORY QUESTIONNAIRE

Patient's Name: _____ Date: _____

Age:_____ Occupation: _____ Left Or Right Handed

Referring Physician: _____

Date of injury: _____ Type of injury: Accident Surgery N/A

Have you had a recent x-ray, CT scan, MRI?
Yes No If so, when and where? _____

Medical Conditions you currently or previously had. Please circle all that apply:

Angina/Chest Pain	Allergies/Asthma	Back Pain	Bowel or Bladder Disease	Cancer
Cataracts	CRPS	Diabetes	Dizziness/Vertigo	DVT's
Emphysema	Epilepsy	Fibromyalgia	Gout	Heart Disease
Hypertension/HBP	Hearing Loss	Incontinence	Kidney Disease	Lung Disease
Hepatitis	Lyme Disease	Myofascial Pain	Multiple Sclerosis	Neck Pain
Neuropathy	Numbness	Osteoporosis	Osteoarthritis	Pins & Needles
Reflux/GERD	Stroke	Seizures	Spasms	TB
Rheumatoid Arthritis	STD's	Skin Disease	Trigger Points	Are you currently pregnant? Yes No

Other conditions: _____

Please list any past surgeries: _____

What is your current pain level within the past 48 hours? (Please circle)

At its worst	0	1	2	3	4	5	6	7	8	9	10
Current	0	1	2	3	4	5	6	7	8	9	10
At its best	0	1	2	3	4	5	6	7	8	9	10

What improves the pain? _____

What worsens the pain? _____

Describe your current symptoms: _____

Have you had previous treatment for this condition? Yes No

If so when and where? _____

Please list all medications, including over the counter & herbal supplements: _____

_____

What would you like to achieve through Physical Therapy? _____

Are you currently under the care of another health care professional? Yes No
(i.e. MD, DO, CRNP, DC, Psychiatrist, Psychologist)

The information above is accurate as possible. I understand that it's my responsibility to report any significant changes to the information above or about my current condition.

Signature: _____ Date: _____

8865 Stanford Boulevard ▪ Suite 114 ▪ Columbia, MD ▪ 21045 ▪ (410) 290-4480 ▪ www.touchstonecolumbia.com

First Name:_____

Middle Initial:_____

Last Name:_____

Date of Birth: _____

Insurance Authorization

I authorize Touchstone Therapy & Wellness to apply for benefits on my behalf for services rendered by Touchstone Therapy and Wellness. I request payment from my insurance company be made directly to Touchstone Therapy and Wellness. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claims. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided, when a statement is rendered. ****For patients covered by PIP:** When coverage under my PIP has been exhausted, my primary insurance will be billed, I will be responsible for any back dated co-pays, co-insurance or other payments not covered by PIP. It can take PIP 3 to 6 weeks to notify us of exhaustion of benefits. I realize my primary insurance will then be billed for all claims not covered under PIP and I will be responsible for all co-pays, co-insurance, and other payments not covered by PIP.***

_____ _____

Signature of Subscriber or Beneficiary Date

Acknowledgement of Cancellation and No Show Policy

In order to achieve your therapy goals, it is absolutely necessary that you attend all of your scheduled appointments. Touchstone Physical Therapy requires 24 hour advance notice for any cancellation. We recognize that emergencies do happen, however if you are unable to give 24 hour advance notice or you do not show for your scheduled appointment, an administrative fee of $25.00 will be billed to you.

I have read the above stated policy and agree to be responsible for my health and for any fee associated with my inability to adhere to this policy.

_____ _____

Patient or Responsible Party's Signature Date

Acknowledgement of Practice's Notice of Privacy Practices:

By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices , and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices and agree to its terms.

I hereby authorized release of my medical records related to:_____ to Touchstone Therapy and Wellness, LLC. I hereby authorize Touchstone Therapy and Wellness to forward any records pertaining to my treatment to my doctor, primary care physician or specialist.

_____ _____

Patient or Responsible Party's Signature Date