touchstone
Physical Therapy & Wellness

Who may we thank, for referring you to our practice_____

General Information	Referring Physician
Patient Name: Mr. Mrs. Ms. Dr.	Should we send medical records to this doctor? Y N
Last Name: Initial:	Name:
First Name:	Phone #
Address:	**Primary Care Physician**
	Should we send medical records to this doctor? Y N
City:	Name
State: Zip:	Phone #:
Date of Birth:	**Responsible Party/Guarantor**
Home Phone:	Name:
Work Phone:	Address:
Cell Phone:	Relationship:
Email:	Phone #:
Please circle the best way for us to confirm your appt:	**Emergency Contact**
Home Work Cell Email	Name:
Employer:	Relationship:
Occupation:	Phone number where they can be reached in case of an emergency:

Reason for Visit			
Complaint & Date of Onset:			
Surgery	Y/N	Previous Physical Therapy:	Y / N
	Date:		Date of last visit:

Acknowledgement of Practice's Notice of Privacy Practices:

I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

I hereby authorize Touchstone Physical Therapy and Wellness to forward any records pertaining to my treatment to my doctor, primary care physician or specialist. I also authorize Touchstone Physical Therapy and Wellness staff to contact me via telephone or email (per my designation) regarding future appointments or other issues related to my care at this clinic.

Patient or Responsible Party's Signature: **Date:**

Touchstone Physical Therapy & Wellness staff may leave messages related to my care via: (check all that apply)

Telephone ☐ Email ☐ Other ☐:

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify):_____

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Thank you for choosing us as your health care provider. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our **Financial Policy**, which we require you, the patient or guarantor, to read and sign prior to any treatment. You are required to present a valid insurance card at your first visit and as needed throughout your care. We will not become involved in disputes between you and your medical insurance company regarding eligibility, co-payments, co-insurance payments, covered charges, etc. other than to supply factual information as necessary.

PLEASE REMEMBER THAT BILLING YOUR INSURANCE COMPANY IS A SERVICE WE CHOOSE TO PROVIDE AS A COURTESY TO YOU, THOUGH WE ARE NOT REQUIRED TO DO SO.

- All copays, coinsurance, and deductible amounts must be paid at the time of your appointment.
- A $25 fee will be added to all returned checks.
- It is your responsibility to make sure all required referrals and physician prescriptions are obtained prior to treatment.

Please initial next to each section

___ **Contracted Insurance:** If we are currently a contracted provider with your insurance company, we will bill them for you. You must have a current insurance card with the billing address. In the event your insurance company denies the claim, Touchstone Physical Therapy and Wellness retains the right to bill you as the responsible party for reimbursement. If you have a deductible, we require that you pay $100 for the initial visit and $70.00 at each visit until your deductible has been met. That actual amount due may be more than $70 at each visit, you are responsible for any additional financial responsibility assessed by your insurance.

___ **Motor Vehicle Accidents:** If you are receiving treatment as a result of an automobile accident, you are responsible for paying any unpaid portions of your bill not covered by the Personal Injury Protection (PIP) clause of your automobile insurance or your medical insurance. Because you are receiving these services, you have the final responsibility to pay for those services. We also require that you provide your medical insurance information at your first visit. Once your PIP is exhausted, we will bill your medical insurance, however, you will be responsible for any balance not paid by your medical insurance carrier including, but not limited to, co-insurance, co-payments and deductibles. You must complete our auto insurance paperwork prior to your first appointment.

___ **Missed Appointment Policy:** Please be considerate and call 24 hours in advance to cancel. If you do not give 24 hour notice or do not show for two consecutive appointments, then we reserve the right to cancel all future appointments.

___ **Late Arrival:** It is imperative to arrive on time. Your late arrival will impact your treatment session, as well as other patients scheduled that day. If you arrive more than 15 minutes after your scheduled appointment time, we reserve the right to schedule your appointment for another day.

___ **Collection Agency:** Please note that in the event that you fail to make payment when due, this account may be referred to a collection agency for collection. In that event, the contingency fee assessed by the collection agency will be added to the principal and interest due as well as any attorney fees—these fees will increase the balance you owe.

___ **Changes to Insurance Coverage.** If there are any changes to your insurance, you are responsible to advise us of those changes and present the new card for our records

___ **Usual & Customary Rates:** Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area.

Assignment of Benefits

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. I have read, understand and agree to this Financial Policy.

X_____ _____ **Date:** _____

Patient or Guarantor Signature **Print Name of Patient/Guarantor**

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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: _____

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TO BE FILLED OUT BY PHYSICAL THERAPIST

Subjective/History

Posture

Mobility

Palpation

Balance

Edema

Joint Mobility

Muscle Mobility

Neural Mobility

MMT

Gait

Special Test