LAST NAME	FIRST NAME , INITIAL	DOB	SOCIAL SECURITY NO	SEX F / M	MARITAL STATUS __ SINGLE __MARRIED
ADDRESS	CITY	STATE	ZIP CODE	EMAL ADDRESS	
OCCUPATION	CELL PHONE NO	WORK PHONE	EMPLOYER	EMPLOYER ADDRESS	
CITY	STATE	ZIP CODE			

EMERGENCY CONTACT

CONTACT NAME	RELATION TO PATIENT	CELL PHONE	WORK PHONE	HOME PHONE

MEDICAL HISTORY

__DIABETES	__HEART PROBLRMS	__SEIZURES	__STROKE	__ NUMBNESS/TINGLING	__HIGH BLOOD PRESSURE
__BREATHING DIFFICULTIES	__PREGNANT	__PACEMARKER	_SIMILAR SYMPTOMS	__HEPATITIS C	__STD
CONTAGIOUS DISEASES:		ALLERGIES Y/N	STROKE Y/N , PLEASE LIST DATE:		
Y/N SURGERIES LAST 10 YEAR:	Y/N HOSPITALIZATION:	Y/N METAL IMPLANTS:	Y/N BROKEN BONES:		
Y/N OTHER :	PLEASE LIST ALL CURRENT MEDICATIONS:				

INJURY INFORMATION

IS THIS WORK RELATED INJURY: Y/N	DATE OF INJURY:	IS THIS AN AUTO ACCIDENT: Y/N	DATE OF INJURY:

CURRENT PROBLEM

HOW DID IT START?	WHEN DID IT START?	WHERE DID IT START? (WORK,HOME,ETC)
HOW OFTEN DOES IT OCCUR?	CIRCLE HOW STRONG: 0 1 2 3 4 5 6 7 8 9 10	

Have you been treated for this problem before? Yes/No

If yes, what type of treatment? _____

Did the above treatment help? Yes/no

Patient Financial Policy for Preferred Physical Therapy

Patient's Name: _____

Commercial Insurance Carrier, Medicare, Medicaid, Worker's Comp and Auto Insurance: We will bill most insurance carriers for you if proper paperwork is provides to us. if an insurances carrier has not paid within 60 day of biling,fees are due and payable in full from you. Any outstanding balances, deductibles and copy are due at the time of services. Methods of payment: our office accepts the following payment methods: Cash, Personal Check, and Patient Financing options for those patients who are credit worthy.

For returned checks we assess a $25.00 NSF charge.

If not paid according to the terms the patient understands that our office reports to an outside collection agency.

Deductible: _____ Co-pay: _____ Coinsurance: _____

I have read, understood and agreed to the above financial policy for payment of Professional fees.

Signature: _____ Date: _____

Appointment Policy

To maximize our effort to provide the best possible treatment for each of our patients, please allow 24 hour notices for your appointment cancellation. You can leave a message at 313.724.6336.

I understand the above policy and my signature affirms here unto that I acknowledge this policy.

Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

CONSENT AND ACKNOWLEDGEMENT

The Healthcare Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program which requires that all medical records and other individually identifiable health information used or disclosed by us in any form are kept properly confidential. This gives you the patient, rights to understand and control how your health information is use.

By signing this consent form, I authorize Preferred Physical Therapy Services to use my protected health information to carry out the following:

- Treatment
- Obtaining payment from third-party payers (insurance companies)
- Day-to-day health care operations of your practice

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or other healthcare operations, but you are not required to agree to these restrictions.

I understand that I may revoke this consent in writing at any time. However, any use or disclosure that occurred prior to the date i revoke this consent will not be affected.

I, the undersigned, acknowledge with my signature that I have received a paper copy of the notice of information practices and hereby consent it the use and disclosure of my health information for purposes noted.

_____ _____

Patient's Signature Date

_____ _____

Parent's/Guardian's Signature Date