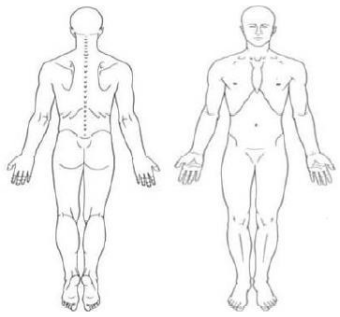
Office use only
Time: Ins:

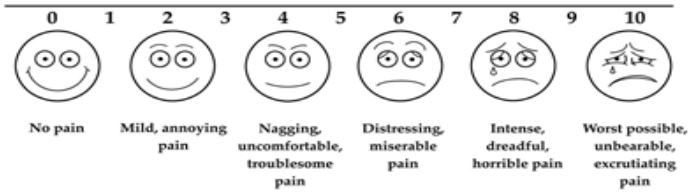
1. **Name: _____** **Date of Birth: ___/___/____**

2. **When did the problem first begin? ___/___/20__**

3. **Briefly describe your primary reason for coming to physical therapy and "x" on the diagram your primary area of pain/symptoms?**



4. **On a scale from 1 to 10; what is the worst your pain has been in the past several days? _____**



5. **Please list prescription/over the counter medications and supplements your are currently taking or bring a copy with you to your first appointment.**

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

6. **Please list surgeries / hospitalizations / MRIs / Xrays include year and reason**

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Patient Signature: _____ **Date: ____/_____/_____**

Hands On Physical Therapy of Mentor, LLC

PATIENT INFORMATION			
Patient's Name First:	Last:	Date of Birth:	
Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	Work Phone:	
Preferred Method of Contact: [ ] Phone [ ] Text	Are you receiving Home Care of any type? [ ] Yes [ ] No		
Marital Status: [ ] Married [ ] Single [ ] Widow [ ] Divorce / Other			
Gender: [ ] Male [ ] Female	Employed: [ ] Yes [ ] No [ ] Retired [ ] Student		
Auto Accident (need EXACT date if reporting to Auto Ins. or Lawyer) _____-_____-_____			
Email Address:			
Can we contact you by email for treatment information and facility news? [ ] Yes [ ] No			
Emergency Contact: Phone: ( )			

PATIENT INSURANCE INFORMATION - PLEASE BRING YOUR INSURANCE CARD		
Primary Insurance Company:		ID #:
Name of Subscriber:	Date of Birth:	Group #:
Relationship to Subscriber: (Circle One) Self / Spouse / Minor / Other		
Employer:	Work Phone:	
Secondary Insurance Company (If Applicable):		ID #:
Name of Subscriber:	Date of Birth:	Group #:
Relationship to Subscriber: (Circle One) Self / Spouse / Minor / Other		
Employer:	Work Phone:	

GUARDIAN INFORMATION (IF UNDER 18 YEARS OLD)			
Name Last:	First:	M.I.:	SSN:
Address:	City:	State:	Zip:
Relationship to Subscriber: (Circle One) Self / Spouse / Other	Date of Birth:		
Employer:	Work Phone:		

CONSENT FOR TREATMENT

Consent for Treatment: I understand I have the right to choose my physical therapy provider and have chosen Hands on Physical Therapy of Mentor, LLC and hereby authorize and give my consent for HOPT to furnish physical therapy care and treatment deemed necessary or advisable in evaluating or treating my physical condition. I further understand no guarantees have been made to me as to the outcome of treatment.

Patient Signature:		**Date:**
Parent / Guardian / Guarantor Signature:		**Date:**

Hands On Physical Therapy of Mentor, LLC

OFFICE POLICY AND FINANCIAL RESPONSIBILITY

PATIENT INFORMATION CONSENT: I have read and fully understand Hands on Physical Therapy of Mentor, LLC's Notice of Information Practices. I understand that HOPT may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations by notifying the practice. I also understand that Hands on Physical Therapy of Mentor, LLC will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Hands on Physical Therapy of Mentor, LLC's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____
Initials

ATTENDANCE, CANCELLATION, and NO SHOW: Attendance at your appointments is very important because it can make the difference between whether or not you succeed in your plan of care. Our physical therapist set aside 45 minutes for your appointment in order to provide you with high quality care. While we understand you may need to cancel an appointment because of unforeseen circumstances, we do require at least 24 hours notice of cancellation. There is a $25 charge for cancellation without prior notice and $50 for not showing up for your appointment. This charge is not covered by your insurance, and you are required to pay this fee personally.

_____
Initials

FINANCIAL RESPONSIBILITY: As a courtesy to you, Hands on Physical Therapy of Mentor, LLC will file your medical insurance claims. The contract between you as a patient and your insurance company is, however, personal to you. HOPT is not responsible for issues between the patient and insurance carrier, nor can HOPT intervene or negotiate for either party on disputed claims. Please advise us immediately if you change insurance coverage while undergoing treatment. Physical therapy equipment and/or supplies are typically not reimbursable by the insurance carrier. As such, HOPT requires payment by the patient for any equipment/supply at the time the order is placed. HOPT will provide a receipt as documentation of the purchase so you may pursue reimbursement personally. HOPT accepts cash, visa, mastercard, or discover as payment options.

_____
Initials

CONSENT TO CONFIDENTIAL MEDICAL INFORMATION

I hereby authorize Hands on Physical Therapy of Mentor, LLC and any of its employees to use or disclose my Patient Health Information to my doctor/dentist that is listed below:

[ ] Yes, I would like my doctor/dentist to be contacted in regards to the results of my physical therapy treatments.
[ ] No, I would prefer NOT to have my doctor/dentist contacted in regards to the result of my physical therapy treatment.

Physician Name: _____ Telephone: _____

Address: _____ City: _____ State: _____ Zipcode: _____

PATIENT AUTHORIZATION

- By my initials and signature I understand these policies and my financial obligations for services rendered.

- I hereby assign payment of benefits by my insurance company to Hands on Physical Therapy of Mentor, LLC, and I accept responsibility to ensure my insurance carrier makes payment on my account within 90 days. Lack of payment by my insurance carrier will result in all charges being transferred to my personal balance on my statement.

- I hereby agree to pay any office visit/co-payment charges at time of visit.

- I hereby agree to promptly pay my personal account balance including co-insurance or unmet deductible upon receipt of my statement. I understand and agree that responsibility for payment for services rendered is mine, due and payable unless other financial arrangements have been made. In the event of default, I agree to pay such collection costs and reasonable attorney fees as may be required to effectively collect the debt.

- I expressly authorize HOPT to contact myself at the phone numbers and email addresses that I have provided, including via autodialer, precorded messages and text messages.

Patient Signature: _____ **Date:** _____

Parent / Guardian / Guarantor: _____ **Date:** _____