FULTZ
PHYSICAL THERAPY & JOINT REHAB

(Please Print Clearly)

Patient's First Name: _____ Last Name: _____ Middle: _____

Mailing Address: _____ City: _____ St: _____ Zip: _____

Street Address: _____ City: _____ St: _____ Zip: _____

DOB: ___ / ___ / ___ Patient's SS#: ___ / ___ / ___ DL #: _____ Gender: ☐ Male ☐ Female

Hm. Ph#: (___) _____ Cell #: (___) _____ Email: _____

Patient's Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other Student: ☐ Full-time ☐ Part-time

Employment Status: ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Self-Employed ☐ Retired ☐ Disabled

Place of Employment: _____ Occupation: _____

Wk.#: (___)_____ Address: _____ City:_____ St:____ Zip:_____

Spouse's Name: _____ Spouse's DOB: ___ / ___ / ___ Spouse's SS#: ___ / ___ / ___

Spouse's Place of Employment: _____ WK#: (___) _____

Responsible Party/Guardian: (If not the patient; or If patient is a minor (under the age of 18):

First Name: _____ Last Name: _____ Middle: _____

Mailing Address: _____ City: _____ St: _____ Zip: _____

Street Address: _____ City: _____ St: _____ Zip: _____

DOB: ___ / ___ / ___ SS#: ___ / ___ / ___ DL #: _____ Hm. Ph#: (___) _____

Cell #: (___) _____

Place of Employment_____ Wk.#: (___)_____

Address: _____ City: _____ St: ____ Zip: _____

Emergency Contact: _____#(___)_____ Relationship: _____

Primary Care Physician _____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE:

I authorize the release of any and all medical information necessary to process my claim for services provided by Fultz Physical Therapy and Joint Rehab, and request payment of benefits to Fultz Physical Therapy and Joint Rehab, LLC.

I hereby consent to the release and disclosure of my personal health information to Fultz Physical Therapy and Joint Rehab, LLC. This release authorization includes my personal health information consisting of MRI results, test results, etc. for the purpose of deciding plan of treatment.

Patient's/Responsible Party's Signature: _____ Date: _____

Patient's Name: _____ DOB: ____/____/_____ Date completed:_____

Referring Physician:_____ Return Date to Physician:_____

What caused you to seek physical therapy/medical attention? _____

Your condition is related to: ☐ Employment ☐ Auto Accident ☐ Home ☐ Other

Date of condition/accident: _____/_____/_____ State Accident Occurred: _____

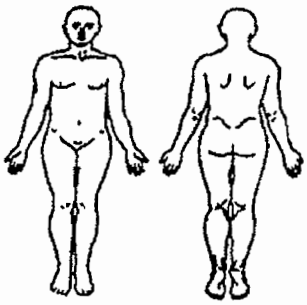
What is your major compliant? Please be as detailed as possible_____

_____

Have you had this problem before? ☐ Yes ☐ No

Mark the location of your pain with an "X":

FRONT BACK



If you have pain, what is your pain level? (0= No Pain, 10 = Extreme Pain – Circle)

0 1 2 3 4 5 6 7 8 9 10

No Pain Extreme Pain

What make your pain better? _____

What make your pain worse? _____

Is this pain getting: ☐ Better ☐ Worse ☐ Not Changing

What type of treatments have you received for this condition? ☐ X-Rays ☐ Surgery ☐ Chiropractic ☐ MRI

☐ Medications ☐ Injection ☐ Bone Scan ☐ CT/CAT Scan ☐ Physical Therapy ☐ Home Health

Please describe (agency, etc.)_____

Have you fallen in the last 12 months? ☐ Yes ☐ No If yes, how many times? ____

Did your fall result in any injury? ☐ Yes ☐ No _____

PLEASE CHECK ALL PROBLEMS DIAGNOSED BY A DOCTOR. CIRCLE IF YOU ARE CURRENTLY BEING TREATED.

☐ Bronchitis/Emphysema/Lung Disease ☐ Sciatica ☐ Gout ☐ Heart Disease

☐ Pneumonia ☐ Fibromyalgia ☐ Implants ☐ Lupus

☐ Abnormal Chest X-Ray ☐ Bursitis ☐ High/Low Blood Pressure ☐ Tuberculosis

☐ Chronic Fatigue Syndrome ☐ TMJ Dysfunction ☐ Dizziness/Fainting Spells ☐ Epilepsy

☐ Thrombosis/Phlebitis ☐ Muscular Dystrophy ☐ Pregnant – due date____ ☐ Diabetes

☐ Carpal Tunnel Syndrome ☐ Blood-Borne Pathologies: ☐ HIV ☐ AIDS ☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C

☐ Tumors/ Cancer—Year_____ Type_____ Remission: ☐ Yes ☐ No ☐ Pace Maker—if Yes, date rec'd _____

☐ Sprains/ Dislocations/Broken Bones—Please List:_____

Please list all medications you are currently taking and what they are for [Specific name of medication, dosage, frequency & Route (Example: by mouth), please include over the counter, prescriptions, herbals & vitamins]: _____

_____

_____

Please list any previous surgeries: _____

_____

Height:_____ Weight:_____

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5795 N. Market St., Suite 8
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(318) 489-4298
(318) 489-4299

HIPAA-ACKNOWLEDGEMENT OF RECEIPT
Notice of Privacy Practices

Printed Patient Name: _____

Patient Birth Date:_____

We at Fultz Physical Therapy are required by law to maintain the privacy of and provide individuals with the attached Notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to the Notice, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. If you would like a copy of the Notice, please ask.

I hereby acknowledge that I have reviewed the HIPAA Notice of Privacy Practice document.

_____ _____
Signature of patient or patient's representative/parent Date

_____
Printed name of patient or patient's representative/parent

_____
Relationship to patient

Fultz Physical Therapy and Joint Rehab

May 8, 2020

Patient: _____ Temp: _____*

COVID-19 MEDICAL SCREENING

Have you or any accompanying person had any of the following symptoms within the last two weeks:

Fever greater than 100 degrees?	YES ☐	NO ☐
Cough?	YES ☐	NO ☐
Sore Throat?	YES ☐	NO ☐
Shortness of Breath?	YES ☐	NO ☐
Flu-like Symptoms?	YES ☐	NO ☐
Muscle Pain?	YES ☐	NO ☐
Loss of taste and/or smell?	YES ☐	NO ☐
Have you been in contact with someone who has tested positive for COVID-19?	YES ☐	NO ☐
Have you been tested for COVID-19 and are awaiting results?	YES ☐	NO ☐
Have you tested positive for COVID-19?	YES ☐	NO ☐
Have you traveled outside the United States by air or cruise ship in the last two weeks?	YES ☐	NO ☐

By signing this document, I acknowledge that I have truthfully answered these questions to the best of my ability.

Patient Signature _____ Date: _____

Doctor Signature: _____ Date: _____

COVID-19 PANDEMIC PHYSICAL THERAPY TREATMENT NOTICE AND ACKNOWLEDGEMENT OF RISK FORM

Our goal is to provide a safe environment for our patients and staff, and to advance the safety of our local community. This document provides information we ask you to acknowledge and understand regarding the COVID-19 virus.

The COVID-19 virus is a serious and highly contagious disease. The World Health Organization has classified it as a pandemic. You could contract COVID-19 from a variety of sources.

The COVID-19 virus has a long incubation period. You or your healthcare providers may have the virus and not show symptoms and yet still be highly contagious. Determining who is infected by COVID-19 is challenging and complicated due to limited availability for virus testing.

You can wear a protective mask over your face to reduce infection risks during treatment.

I have read and understand the information stated above:

Patient Signature _____ Date: _____

Doctor Signature: _____ Date: _____

*Temperature will be checked upon each visit. Any temperature registering above 99.5° will be noted here.

FULTZ PHYSICAL THERAPY

Patient Financial Policy

Thank you for choosing us as your healthcare provider. We are committed to providing you with the best possible medical care and partnering with you in your recovery.

Insurance

- We will verify your benefits and help you understand how physical therapy is covered. However, verification of benefits is not a guarantee of payment by the insurance company/attorney.
- You are responsible to inform our office of any changes to your insurance policy or coverage.
- You agree to assume responsibility for payment of fees for provided physical therapy services when charges for my services are denied by my health insurance as a result of delinquent insurance premium payment on my behalf.
- As a courtesy, we will bill your health, auto, or worker's compensation insurance company. If a problem arises, you may be asked to assist us in contacting your insurance company.

Payment Responsibility

After verification of benefits with your insurance company, your responsibility for Physical Therapy services is as follows:

- ☐ Subject to Deductible: $_____ Met: $_____ Remaining Ded: $ _____.
  Once Deductible is met, insurance covers at _____% and you are responsible for _____% of each visit.
- ☐ Deductible Met in Full, insurance pays at _____% and you are responsible for _____% of each visit.
- ☐ Co-Pay $_____/visit, Deductible does not apply.
- ☐ You are responsible for 20% of Medicare allowable charges.
- ☐ If you have multiple insurances, you will be responsible for a portion of your daily charges, in addition to any remaining balances after all insurances have processed your charges.
- ☐ We have approval from your attorney/liability company for services we provide. To be clear, you are ultimately responsible for payment of your account in full, regardless of the outcome of your case.
- ☐ Self Pay - You are receiving a 40% discount off your full charges, excluding orthotics and DME items.
- ☐ Other: _____

Financial Obligations

We accept Cash, Checks, VISA, Mastercard, Discover, and American Express.

- ❖ Payment is due at the time of service.

Cancellation/No Show Policy

We strive very hard to work with you on scheduling, and understand that life and unplanned circumstances happen. If you begin to develop a pattern of not showing up or cancelling your appointment without adequate notice, we reserve the right to charge a $25.00 fee.

I have read Fultz Physical Therapy Financial Policy and agree to comply. My insurance benefits have been explained to me and I understand that I am responsible for any co-pay, co-insurance and/or deductible required by my insurance policy. All patients must complete all patient information forms prior to treatment, including all pertinent insurance information (primary, secondary and/or supplement). Failure to provide us with all insurance information will forfeit our filing with your insurance company; therefore leaving you solely responsible for paying out your account.
Our office is committed to providing you with the best care possible, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask, if you have any questions regarding our fees, financial policy, or your responsibility.

Patient's Signature: _____ **Date:** _____