

West Campus Sports & Orthopedic Physical Therapy

PATIENT INFORMATION

Name: _____ Date of Birth: _____ SS#: _____

Telephone: Home: _____ Cell: _____ Work: _____

Email: Personal: _____ Bus: _____

Address: _____ Apt. _____ City: _____ Zip: _____

Employed by: _____ Occupation: _____

Spouse/Parent's Name: _____ Employed by: _____

Emergency Contact Name: _____ Contact phone #: _____

Insurance Information: Symptoms / Injury due to: Car Accident / Work Injury / Other

Primary Ins. Company: _____ Subscribers Name: _____

Ins. ID #: _____ Group/Claim #: _____

Secondary Ins. Company: _____ Subscribers Name: _____

Ins. ID #: _____ Group/Claim #: _____

If car accident: Name/Phone # of Attorney: _____

Medical History: Referring Dr: _____ Primary Care Dr: _____

Is patient taking any medications: Yes / No (please list or attach list)

Medical Problems: Heart _____ High Blood Pressure _____ Diabetic _____ Cancer _____ Epileptic _____

Osteoporosis _____ Are you Pregnant? _____ Other _____ none _____

Information: When did symptoms or injury occur?

Please describe how symptoms began or how injury occurred:

Please describe what part of body was initially injured:

Has there been a re-injury: Y/N Date: _____ Describe:

Were you able to continue working? Y/N When did you stop working?

When did you return to work? _____

Patient Authorization: I authorize your clinic to provide care for my condition, and the release of any medical information necessary to process my claims through my insurance company. I also authorize payment of medical benefits to West Campus Sports & Orthopedic Physical Therapy for service rendered.

Signature of Patient/ Legal Guardian: _____ Date:

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Cancellation/No-Show Policy

We take our policies regarding cancellations and no-shows seriously at West Campus Sports & Orthopedic Physical Therapy because it can make the difference between whether you succeed in your treatment or not. Usually your referring doctor and/or your therapist has prescribed a set frequency of treatment. Showing up as scheduled for these visits is your most important job. Other than that, all you need to do is follow your therapist's instructions and we will strive to help you achieve your goals in treatment.

Please initial each statement:

_____ * We required **24hours** notice in the event of a cancellation. During business hours, when you call in please have an alternative time in mind. This will ensure you get the full prescribed number of treatments that week whenever possible.

_____ * There is a **\$20.00 charge** for a cancellation without proper notice. This charge will not be covered by insurance and will have to be paid by you personally.

_____ * For Worker's Compensation and Personal Injury patients, documentation of any missed appointments will be forwarded to your Case Manager and Primary Physician which could jeopardize your claim.

When you don't show as scheduled, three people are hurt; **you**, because you don't get the treatment you need as prescribed by the doctor and/or therapist; **the therapist** who now has a space in their schedule since the time was reserved for you personally; and **another patient**, who could have been scheduled for treatment if you had given proper notice.

Please cooperate with us in this regard. We look forward to working with you.

Signature (Patient/Parent/Legal Guardian)

Date

Staff Signature

Date