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 require **24 hours** 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 **$40.00 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