MATRIX
Physical Therapy & Wellness

Patient Information Sheet

Name_____ Date_____

SSN_____ Date of birth_____ Age_____

Address_____City_____Zip_____

Home phone number_____Mobile phone number_____

Driver's License Number_____Email_____

Occupation_____Employer_____

Name of Spouse/Partner_____Spouse's phone number_____

How did you get to us (check all that apply)? ☐ Doctor_____ ☐ Internet Search

☐ Yelp ☐ Referral from friend/family _____ ☐ Health Insurance Website

☐ Other_____ **Were you referred to a specific therapist (name)**_____

Please provide our office with a copy of your primary and secondary insurance along with a copy of your photo ID. We submit claims to insurance companies as a courtesy to our patients, but it is ultimately the patient's responsibility to verify benefits with their insurance company.

Date of injury or when your symptoms began_____Is condition work-related?_____
Is condition related to an automobile accident?_____Is there a lawsuit?_____
If so: Attorney_____Phone_____

If patient is a minor, please give name and address of person legally responsible:
Name_____Phone_____
Address_____

Please give name and address of nearest relative who is not living with you:
Name_____Phone_____
Address_____

Authorization to release information: I hereby authorize Matrix Physical Therapy and Wellness, PC to release any information acquired in the course of evaluation or treatment of the patient to any person or entity which is or may be liable for all or any portion of Matrix Physical Therapy and Wellness, PC charges. A photocopy of this form shall be deemed as valid as the original.

Date:_____ Signature:_____
Patient/Parent/Guardian

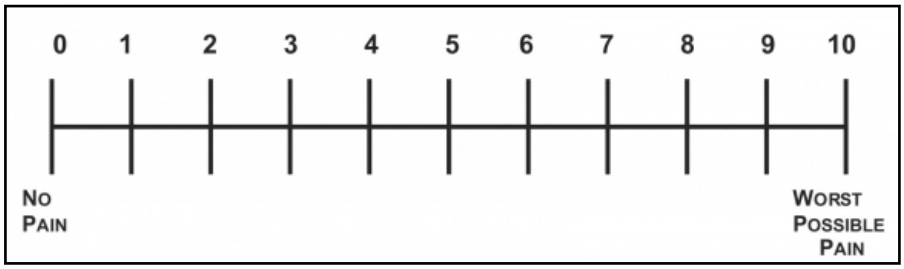
Assignment of Insurance Benefits: The undersigned authorizes direct payment to Matrix Physical Therapy and Wellness, PC of any insurance benefits otherwise payable to the undersigned for professional service charges. It is understood by the undersigned that he/she is financially responsible for charges not covered by this assignment.

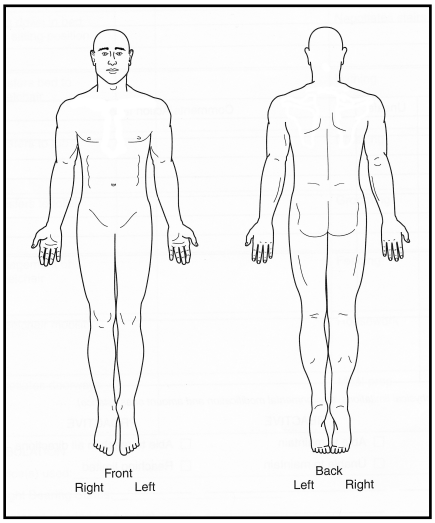
Date:_____ Signature:_____
Patient/Parent/Guardian

Patient name: _____

Patient History

If you have pain, please place a vertical line on the scale below to indicate the level of your pain at its worst:





On the above body diagram, indicate where you have your current symptoms.

Please indicate if you had/have any of the following:

	Yes	No	If Yes, please explain (include dates/treatment):
Cancer / Tumor	___	___	_____
High Blood Pressure	___	___	_____
Heart or Circulation Disorder	___	___	_____
Stroke	___	___	_____
Surgical Implant / Hardware	___	___	_____
Diabetes	___	___	_____
Neurological disorder	___	___	_____
Dizziness	___	___	_____
Pacemaker	___	___	_____
Arthritis	___	___	_____
Osteopenia / Osteoporosis	___	___	_____
Immune Deficiency	___	___	_____
Autoimmune disorder	___	___	_____
Head Trauma / Head aches	___	___	_____
Other Orthopedic injuries/surgeries	___	___	_____
Abdominal pain	___	___	_____
Other_____	___	___	_____

Do you currently or have you previously smoked cigarettes? ___Yes ___No If yes, please describe the frequency of smoking (i.e. packs per day, # of years smoking, etc.):_____If you have quit smoking, when did you quit?_____

Please list results of recent diagnostic studies (X-rays, MRIs, CT scans, PET scans, bone density, blood work, etc.):
_____

Have you had an unusual weight loss recently? ___Yes ___No

List medications you are taking and start date:
_____

Are you pregnant: ____Yes ____No If yes, for how long have you been pregnant?:_____

Have you had physical therapy, occupational therapy or chiropractor treatments this year?
___Yes ___No If yes, please indicate when and how many: _____

Have you had home health services of ANY KIND (including nursing, physical therapy, occupational therapy, speech therapy, etc.)?
____Yes ____No

Date of next appointment with referring physician: _____

Specific Activity / Sport participation: _____

Hand Dominance: Right_____ Left_____ Ambidextrous____

Matrix Physical Therapy and Wellness, PC
Patient Information Consent

I have read and fully understand Matrix Physical Therapy and Wellness, PC's Notice of Privacy Practices. I understand that Matrix Physical Therapy and Wellness, PC 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 if I notify the practice. I also understand that Matrix Physical Therapy and Wellness, PC 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 Matrix Physical Therapy and Wellness's Notice of Privacy Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____	_____	_____
Patient Name	Signature	Date

Matrix Physical Therapy and Wellness, PC
Consent to Treatment

Physical therapy at Matrix Physical Therapy and Wellness, PC (Matrix PT) is a patient care service that is provided in order to manage a wide variety of conditions/diseases. Services are provided to individuals of all ages regardless of gender, color, ethnicity, creed, national origin, sexual identity, or disability.

The purpose of physical therapy is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis and intervention by use of rehabilitative procedures, mobilization, massage, exercises, and physical agents to aid the patient in achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of functional recovery. All procedures will be thoroughly explained to you before you are asked to perform them.

Response to physical therapy intervention varies from person to person; therefore, it is not possible to accurately predict your response to a specific modality, procedure, or exercise program. Matrix PT does not guarantee what your reaction will be to a specific treatment, nor does it guarantee that the treatment will help resolve the condition that you are seeking treatment for. Furthermore, there is a possibility that the physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury.

It is your right to decline any part of your treatment at any time before or during treatment, should you feel any discomfort or pain or have other unresolved concerns. It is your right to ask your physical therapist about the treatment they have planned based on your individual history, physical therapy diagnosis, symptoms, and examination results. Consequently, it is your right to discuss the potential risks and benefits involved in your treatment.

It is difficult to anticipate the cost to you for our physical therapy services due to variations in insurance company co-pays / co-insurance and deductible amounts. Our out-of-pocket physical therapy fees are $225.00 for an initial evaluation and $175 for follow-up visits.

I have read this consent form and understand the risks involved in physical therapy and agree to fully cooperate, participate in all physical therapy procedures, and comply with the established plan of care. I authorize the release of my medical information to appropriate third parties.

Patient Name_____ Signature_____ Date_____

Financial Policy

Thank you for choosing Matrix Physical Therapy and Wellness, PC as your health care provider. We are committed to your treatment being successful. The following is our financial policy. Please read and sign the statement prior to initiating any treatment.

1. All patients must complete the information sheet.
2. **Patients are responsible for contacting their insurance company and verifying their insurance benefits including policy deductibles, co-payments, co-insurance, visit limitations, and any pre-authorization requirements.** As a courtesy, we will also verify your coverage but will not guarantee the accuracy of the information we receive. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Therefore, you are ultimately responsible for knowledge of insurance benefits and for the full payment of your bill.
3. Co-payments or co-insurance payments are due each visit.
4. If you do not have insurance, full payment is due at the time of service.
5. We accept cash, checks, and most credit cards.

We bill insurance companies as a courtesy to our patients. However, you are ultimately responsible for co-payments, co-insurance or any part of the bill not paid by your insurance company. In trying to reduce their own costs, some insurance companies have lately developed a policy of unilaterally declaring "medical necessity has not been established" for portions of treatment. You are still responsible in this case for the services that were rendered.

In order for us to bill an insurance company, patients must provide us with the following documents:

1. A current physician's prescription ordering physical therapy and including a diagnosis, frequency, and duration of treatment (updated as necessary).
2. A copy of your insurance card.

Please be advised that this office will require payment in full for treatments rendered if these documents are not provided. If your insurance company fails to reimburse us within 45 days, you will be responsible for the entire unpaid balance. It is also your responsibility to check with your insurance company regarding the status of your claim.

Depending on your insurance plan, you might be required to pay co-payment or co-insurance for services rendered. This can be a fixed dollar amount per visit (co-payment), or a percentage of the charge for the visit (co-insurance). Since we will not be able to ascertain the exact dollar amount of a co-insurance payment in advance, we will estimate that amount and collect it at each visit. Once we have received payment from the insurance company, we will bill you for any amount not covered in the estimation or issue a refund check to you if over-payment is determined. Payment is expected within 15 days of the date of the statement. A finance charge of 1.5% will be assessed on all delinquent accounts.

I understand that I am fully and completely responsible for the knowledge of my policy's benefits and limits, including number of visits, deductible amount, requirement of pre-authorization (when indicated), and co-insurance or co-payment amounts.

A charge of $60.00 will be billed for any missed appointment without 24 hours notice.

Please let us know if we can help you with any of the above information.

By my signature below, I recognize and accept that I am ultimately financially responsible for all charges for services rendered including, but not limited to, any services or fees denied or not covered by my insurance company.

I certify that I have read and fully understand all of the above information.

_____ _____

Signature of patient or responsible party Date