ALDEN Physical Therapy

764 Bessemer Street, Suite 102, Meadville, PA 16335
P: 814-337-9535 | F: 814-337-8140

DATE: _____

Name:_____Email:_____

Cell Phone:_____Home Phone:_____

Home Address:_____City:_____State:_____Zip:_____

Social Security #:_____Date of Birth:_____Age:_____

Employer:_____Employer Phone:_____

Employer Address:_____

Spouse or Parent Name:_____Relationship to Patient:_____

Spouse or Parent Employer:_____Spouse or Parent Date of Birth_____

Family Physician:_____

Referring Physician:_____Date of Return:_____

Nature of Problem:_____

Date of Injury:_____Work Related Y/N:_____Auto Accident Y/N:_____

Person to contact in case of emergency:_____Phone:_____

Whom may we thank for referring you to us?_____

Name of Insurance Co:_____Policy Holder:_____

Policy or Claim#:_____Policy Holder's Date of Birth:_____

Updated 01/2020

MEDICAL HISTORY

Have you ever had or do you currently have any of the following:

	Yes	No		Yes	No	
High or Low Blood Pressure	____	____	Arthritis	____	____	Type _____
Heart Disease	____	____	Asthma	____	____	
Heart Attack	____	____	Epilepsy	____	____	
Diabetes	____	____	Bone/Joint Surgery	____	____	
Circulation Problems	____	____	Any Spinal Surgery	____	____	
Joint Problems	____	____	Cardiovascular Condition	____	____	
Neurological Condition of the			Cancer	____	____	
Central Nervous System (CNS)			Chronic Lung Disease	____	____	
such as Parkinson's, CVA, MS, etc.	____	____	Depression/Anxiety	____	____	
Thyroid problems	____	____	Other _____			

If you've had surgery, please describe: _____

_____

Have you ever had similar problems? _____

If yes, please note previous treatments? _____

Which treatments helped? _____

Which treatments did not help, made worse? _____

On a scale of 0 to 10, what is your pain level? Now: _____Best: _____ Worst: _____

Have you had a history of pain for more than three months? _____

Please list any current medications you are currently taking_____

_____

CONSENT FOR TREATMENT

I acknowledge that I have been referred to ALDEN PHYSICAL THERAPY for physical therapy services and will be subjected to various therapeutic procedures. I understand that the prescribed treatments may take the form of moist heat, cold, ultrasound, electrical stimulation, traction, therapeutic exercise, soft tissue and joint mobilization, and other recognized procedures utilized by physical therapists. I hereby authorize my consent for Randall B. Schlosser. P.T. or other physical therapists in his employ to treat me as prescribed.

Signed: _____

AUTHORIZATION FOR PAYMENT

I acknowledge that I am financially responsible to ALDEN PHYSICAL THERAPY for any debts not covered by third party payers which are incurred during the period of time in which I am receiving treatment for my physical ailment as presc ribed by my physician. Furthermore, should my third party payer not permit assignment of benefits, I understand that the payment for services rendered will come to my residence. I understand that it is my responsibility to sign the check over to ALDEN PHYSICAL THERAPY and agree to do so promptly.

Signed: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize and direct ALDEN PHYSICAL THERAPY to release information concerning my physical condition to insurance companies and other third party payers who are involved in processing claims for payment of treatments and administe red by S.P.T. I also authorize the release of medical information concerning my physical condition to my employer, if I am being treated for a work related injury, and S.P.T. is on my employer's designated list of duly licensed practitioner s of the healing arts. Medical information concerning my physical condition may also be released to my employer of other parties if S.P.T. is in receipt of my signed authorization from such other parties. I also authorize S.P.T. to obtain medical records from medical offices relating to my current treatment.

Signed: _____

I request that payment of authorized insurance benefits be made either to me or on my behalf for any services fu rnished me to ALDEN PHYSICAL THERAPY. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits, or the benefits payable for related services.

Signed: _____

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