



SAEGERTOWN Physical Therapy

341 Main Street, Saegertown, PA 16433
P: 814-783-0051 | F: 814-783-0053

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: _____

MEDICAL HISTORY

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

	Yes	No		Yes	No	Type
High or Low Blood Pressure	_____	_____	Arthritis	_____	_____	_____
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 SAEGERTOWN 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 SAEGERTOWN 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 prescribed 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 SAEGERTOWN PHYSICAL THERAPY and agree to do so promptly.

Signed: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize and direct SAEGERTOWN 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 administered 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 practitioners 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 furnished me to SAEGERTOWN 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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