SAEGERTOWN PT
SCHLOSSER
PHYSICAL THERAPY
ALDEN PT (MEADVILLE)

DATE:_____

Name:_____Email:_____

Cell Phone:_____Home Phone:_____

HomeAddress:_____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:_____

Update 01/2024

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 _____			
Do you have a pacemaker?	☐	☐				

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 taking: _____

_____

_____

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CONSENT TO 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 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 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 administered by A.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 A.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 A.P.T. is in receipt of my signed authorization from such other parties. I also authorize A.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 on my behalf for any services furnished me, to ALDEN PHYSICAL THERAPY. I authorize ALDEN PHYSICAL THERAPY to release information about me to the Health Care Financing Administration and its agents any information needed to determine these benefits.

Signed: _____

HIPAA NOTIFICATION

Notice of Privacy Practices for Protected Health Information

Health Insurance Portability & Accountability Act of 1996 (HIPAA)

Due to increased awareness of the need for more strict guidelines regarding privacy of your protected health information, the Health Insurance Portability & Accountability Act of 1996 (HIPAA) was legislated, effective April 14, 2003. As part of this law, Conneaut Physical Therapy is required to provide you with the option of receiving a copy of this Notice. You are able to receive this Notice by paper if you desire.

PLEASE SELECT ONE:

☐ Waiver

I, the undersigned, am aware of my right to receive a paper copy of the above Notice and have declined such Notice.

Print Name:_____

Signature: _____

Date Signed: _____

OR

☐ Acknowledgement (Receive HIPAA Paper Copy)

I, the undersigned, acknowledge with my signature that I have received a paper copy of the above mentioned Notice. I understand that it is my responsibility to read and be aware of these rights outlined in the Notice.

Print Name: _____

Signature: _____

Date Signed: _____