MERK PHYSICAL THERAPY

Patient Information

Driver's License Number	Social Security Number	
Last Name and First Name		
Date Of Birth	Sex Male or Female	
Address		
City	State	Zip Code

Contact Information

Home Phone	Cell Phone
E-mail Address	

Emergency Contact

Last Name and First Name	
Phone Number	Relationship

Informed Consent/Privacy Policies

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, manual therapy, exercises, and physical agents to aid the patient in achieving their maximum potential within their capabilities. All procedures will be thoroughly explained to you before you are asked to perform them. However, if you have any questions regarding the type of exercise you are performing and any specific risks associated with your exercises, your therapist will be glad to answer them.

I am fully aware of my medical diagnosis and I give my consent to Merk Physical Therapy to provide treatment for my condition. I 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.

I have received or have been advised that the full notice of privacy practices is available upon request.

Signature:	Date:

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Cancellation Policy

Thank you for making Merk Physical Therapy your choice for therapy services. In order for us to help you, we have found that consistent attendance is the key to our patient's success. For this reason, all therapy sessions are important and cancellations/no shows are discouraged.

A cancellation or no show less than 24 hours prior to your appointment time will be subject to a $25 fee.

Please understand that a last minute cancellation is taking a time away from another patient who needs therapy. All cancellations and absences will be documented in your medical record and reported to your physician and insurance company or third party payor.
Cancellation/No Show fees are not covered by insurance companies and become the responsibility of the patient.
I have read and understand the above cancellation/no show policy. I understand it is my responsibility to notify Merk Physical Therapy if I cannot attend my scheduled appointments.

Patient Signature:	Date:

Payment Policy

We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. Merk Physical Therapy will verify your coverage prior to your first visit. However, please be aware that some of the services you receive may not be covered by Medicare or other insurers.

Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges that insurance companies tend to cover. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

Signature:	Date:

Merk PT uses an electronic billing system. All patients with a balance on their account will receive statements by email. Please let us know if you would prefer to receive your statement by mail.

Signature:	Date:

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PAST MEDICAL HISTORY FORM

Patient Name: _____ Date: _____

Social Security Number: _____

Are you presently working? ☐ Yes ☐ No Who is your employer? _____

Date of next physician visit: _____ _____

Date of injury / onset: ____/____/____ Have you ever had these symptoms before? ☐ Yes ☐ No

Check which apply to your symptoms:

☐ Work related injury ☐ Recurrence of previous injury ☐ Injury related to falling
☐ Motor vehicle accident ☐ Injury related to lifting ☐ Other: _____
☐ Cause unknown ☐ Athletic / recreational injury

Have you had a related surgery? ☐ Yes ☐ No

Do you have, or have you had any of the following?

	Yes	No		Yes	No
Diabetes	☐	☐	Allergies to Aspirin	☐	☐
Chest Pain / Angina	☐	☐	Allergies to Heat	☐	☐
High Blood Pressure	☐	☐	Allergies / Poor tolerance to Cold	☐	☐
Heart Disease	☐	☐	Other Allergies	☐	☐
Heart Attack	☐	☐	Hernia	☐	☐
Heart Palpitations	☐	☐	Seizures	☐	☐
Pacemaker	☐	☐	Metal Implants	☐	☐
Headaches	☐	☐	Dizziness / Fainting	☐	☐
Kidney Problems	☐	☐	Recent Fractures	☐	☐
Are you pregnant?	☐	☐	Surgeries	☐	☐
Cancer	☐	☐	Skin Abnormalities	☐	☐
Osteoporosis	☐	☐	Sexual Dysfunction	☐	☐
Bowel / Bladder Abnormalities	☐	☐	Nausea / Vomiting	☐	☐
Urine Leakage	☐	☐	Ringing in your ears	☐	☐
Asthma / Breathing Difficulties	☐	☐	Rheumatoid Arthritis	☐	☐
Liver / Gallbladder Problems	☐	☐	Special Diet Guidelines	☐	☐
Smoking	☐	☐	Hypoglycemia	☐	☐
Stroke/CVA	☐	☐	Other: _____		

If yes on any of the above, please briefly explain and give approximated date:

Is there any other information regarding your past medical history that we should know about?

Are you presently taking Medication? ☐ Yes ☐ No
If yes, please list what medications and for what condition:

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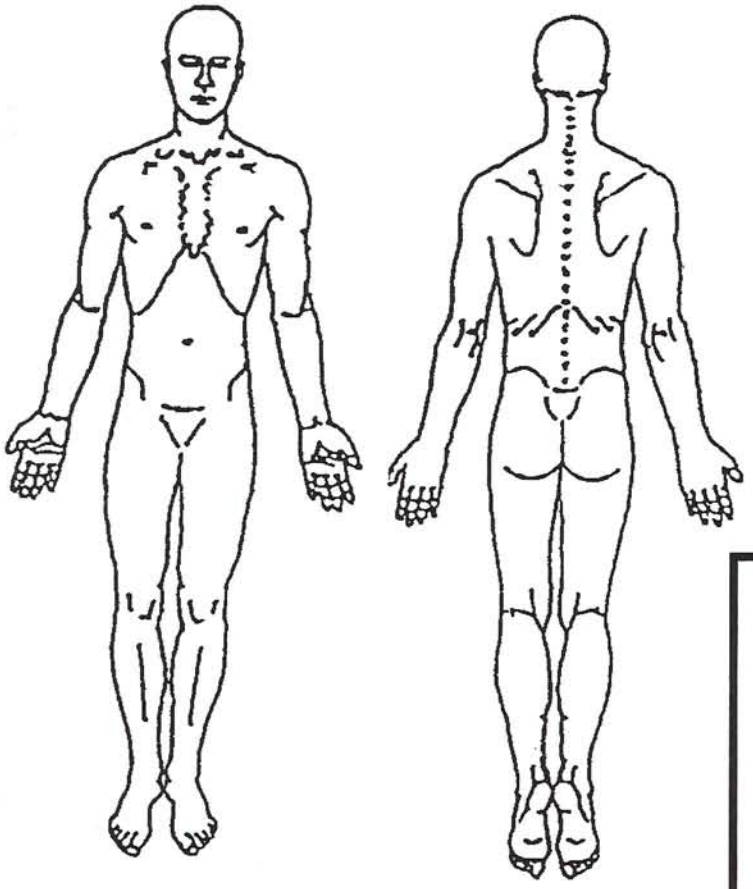
In the rare instance of an emergency, whom should we contact?

Name: _____

Phone Number: _____

Please indicate below where your symptoms are located.



KEY:

Numbness	**========**
Pins & Needles	**ooooooo**
Burning Pain	**xxxxxxxx**
Stabbing Pain	**////////**

If you are having pain, please rate the intensity of your pain on a scale of 0 to 10, with 0 being no pain and 10 being the worst pain possible: _____.

_____ _____ _____ _____

Patient's Signature Date Signature of Guardian if patient is a minor Date

_____ ____/____/____

Therapist Signature Date