

A. PATIENT

Please Print Legibly on Form			Account #	
Last Name	First Name	Middle Initial		
Address	Apt #	City	State	Zip
Home Phone ()	Mobile Phone ()	Work Phone ()		
DOB (mm/dd/yy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	SSN #		
E-mail Address				
Employment Status <input type="checkbox"/> Employed <input type="checkbox"/> Un-Employed <input type="checkbox"/> Retired <input type="checkbox"/> Student <input type="checkbox"/> Other:				
Employer Name				

B. EMERGENCY CONTACT

Last Name	First Name	Middle Initial
Home Phone ()	Mobile Phone ()	Work Phone ()
Relationship to Patient <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Grandparent <input type="checkbox"/> Sibling <input type="checkbox"/> Friend <input type="checkbox"/> Other:		

C. GUARANTOR / RESPONSIBLE PARTY (fill out if patient is a minor)

Last Name	First Name	Middle Initial		
Address	Apt #	City	State	Zip
Home Phone ()	Mobile Phone ()	Work Phone ()		
DOB (mm/dd/yy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	SSN #		
Employer				
Relationship to Patient <input type="checkbox"/> Parent <input type="checkbox"/> Grandparent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other:				

D. INSURANCE (if applicable)

Primary Insurance (copy of card must be on file)		Check here <input type="checkbox"/> if Name, SSN & DOB same as patient.
Insurance Name		
Subscriber (Insured) Name		SSN #
Relationship of Patient to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		DOB (mm/dd/yy)
Secondary Insurance (copy of card must be on file)		Check here <input type="checkbox"/> if Name, SSN & DOB same as patient.
Insurance Name		
Subscriber (Insured) Name		SSN #
Relationship of Patient to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		DOB (mm/dd/yy)

E. ACCIDENT (if applicable)

Work related accident? <input type="checkbox"/> Yes <input type="checkbox"/> No Auto or Other Type Accident? <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, fill out below)		
Insurance Name		Phone ()
Address	City	State Zip
Policy #	Agent / Adjuster Name	
Claim #	Accident Date	Accident State

Patient Name: _____	DOB: _____	Patient ID: _____				
Current employment status ? <input type="checkbox"/> Occupation _____ <input type="checkbox"/> Retired <input type="checkbox"/> Student <input type="checkbox"/> Disabled Work activities mostly include: <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Lifting <input type="checkbox"/> Bending <input type="checkbox"/> Computer <input type="checkbox"/> Driving <input type="checkbox"/> Varied <input type="checkbox"/> Other: _____						
How do you rate your health ? <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor When did your current symptoms begin ? (date) ____/____/____ or (time period) _____ Have you experienced these symptoms before (please explain)? _____						
Do you currently exercise, play sports or have hobbies (if yes, please describe)? _____						
How did your injury occur or symptoms begin (check all that apply)? <input type="checkbox"/> Accident – Work Related <input type="checkbox"/> Bending <input type="checkbox"/> Reaching <input type="checkbox"/> Other (describe): <input type="checkbox"/> Accident – Motor Vehicle <input type="checkbox"/> Falling <input type="checkbox"/> No Apparent Reason <input type="checkbox"/> Accident – Liability / 3 rd Party <input type="checkbox"/> Lifting <input type="checkbox"/> Gradual Onset						
Indicate daily activities you are having trouble with due to this injury or onset of symptoms (check all that apply)? <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Reaching <input type="checkbox"/> Dressing <input type="checkbox"/> Rising <input type="checkbox"/> Turning <input type="checkbox"/> Lying <input type="checkbox"/> Housework <input type="checkbox"/> Bending <input type="checkbox"/> Walking <input type="checkbox"/> Sleeping <input type="checkbox"/> Athletics <input type="checkbox"/> Driving <input type="checkbox"/> Stairs <input type="checkbox"/> Grooming <input type="checkbox"/> Other (describe):						
What treatment & testing have you received (check all that apply)? <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Bracing <input type="checkbox"/> Nerve Conduction Study <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Orthotics <input type="checkbox"/> Myelogram <input type="checkbox"/> Chiropractic <input type="checkbox"/> X-Ray <input type="checkbox"/> Other (describe): <input type="checkbox"/> Injection <input type="checkbox"/> MRI <input type="checkbox"/> Medication <input type="checkbox"/> CT Scan						
If you had surgery , list the type of surgery _____ and date of surgery ____/____/____						
Do you experience frequent episodes of the following (check all that apply)? <input type="checkbox"/> Headaches <input type="checkbox"/> Dizziness <input type="checkbox"/> Nausea <input type="checkbox"/> Ear Ringing <input type="checkbox"/> Balance Control						
Have you noticed a change in your bowel or bladder frequency or control ? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain: _____						
Do you have, or have you had, any of the following (check all that apply)?						
	Yes	No		Yes	No	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Metal Implants	<input type="checkbox"/>	<input type="checkbox"/>	List additional history:
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	
COPD	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	
Currently Pregnant	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Peripheral Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Previous Surgery	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Stroke History	<input type="checkbox"/>	<input type="checkbox"/>	

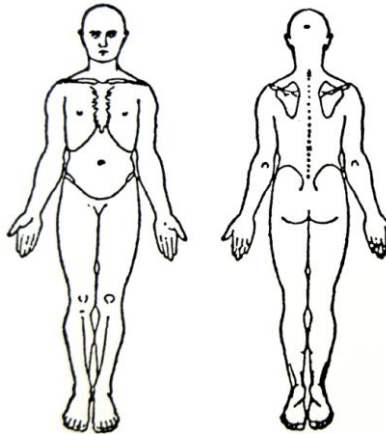
Patient Name: _____ **DOB:** _____ **Patient ID:** _____

Use the following scales to **rate your average symptom level** (*circle the appropriate level for each body part*).
"0" = No Symptoms, "10" = Intense enough to seek emergency assistance

Back: 0 1 2 3 4 5 6 7 8 9 10 **Arm:** 0 1 2 3 4 5 6 7 8 9 10 **Leg:** 0 1 2 3 4 5 6 7 8 9 10

Neck: 0 1 2 3 4 5 6 7 8 9 10 **Hand:** 0 1 2 3 4 5 6 7 8 9 10 **Foot:** 0 1 2 3 4 5 6 7 8 9 10

Please indicate on the chart below, **where specifically you feel the pain** indicated above:



Do you **take any medications**? Yes No If **Yes**, please fill out below.

- See Attached List of Medications.
- Prescription Medications: _____
- Over the Counter Medications: _____

Do you **have allergies** to Latex Lidocaine Cortisone None Known Other _____

Are you **currently receiving home health** services or have you **within the last 4 weeks**? Yes No

Have you had any physical, occupational or speech therapy **this calendar year**? Yes No

If needed, do you have a **family member** or **friend** who can assist you during your recovery and with your care? Yes No

What **goals** do you have for therapy? What do you **hope to accomplish**?

My **next appointment** with my doctor is on ____/____/____ No appt scheduled.

Patient Signature _____ Reviewed By _____

Patient Name:	Patient ID:
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INSURANCE BENEFITS (if applicable) :: As a courtesy, we will make every effort to contact your insurance company to obtain your therapy benefits. The benefit information obtained cannot be considered a guarantee of actual benefits or insurance payment for services rendered. We encourage you to contact your insurance company to verify your benefit information.

MEDICARE (if applicable) :: "I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries any such information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I understand that I am responsible for any health insurance deductibles and coinsurance."

GUARANTEE OF PAYMENT (not applicable for Worker's Compensation patients):: "In consideration of services rendered to me by STAR Physical Therapy, I hereby guarantee payment for any and all services not covered or allowed by insurance. I also understand that all bills are due and payable upon receipt. I understand that the patient responsibility portion of my bill will be due and payable at the time of service. I understand that should my account with STAR become delinquent and turned over to a collection agency, that I, the undersigned, will be responsible to pay all collection agency fees, court costs or any other fees / costs associated with resolving my account balance."

RETURNED CHECKS :: We are happy to accept your personal check, however, if your check is returned for any reason, you expressly authorize your account to be electronically debited or bank drafted for the amount of the check plus any applicable fees. The use of a check for payment is your acknowledgement and acceptance of this policy and its terms and conditions.

CONSENT FOR TREATMENT :: "I hereby consent to such treatment procedures and patient care which, in the judgment of my therapist and/or physician, may be considered necessary or advisable while a patient at STAR Physical Therapy."

WAIVER AND RELEASE :: "I hereby release, discharge and acquit STAR Physical Therapy, it's agents, representatives, affiliates, employees or assigns of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services, including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services."

AUTHORIZATION TO RELEASE MEDICAL INFORMATION :: "I consent to allow STAR Physical Therapy, to use and disclose my protected health information (PHI) within STAR to carry out my treatment, to obtain payment and to carry out health care operations. My PHI may be disclosed to my health plan and/or its agents as necessary to verify benefits, authorize services and process medical claims. My PHI may be disclosed to outside health agencies or institutions involved in my continuing care and/or for emergency care purposes. My PHI may include medical information or any information pertaining to the evaluation, treatment and history. This may include psychiatric, HIV/AIDS, sickle cell, alcohol and/or drug information, coded medical information and charges to my health plan and/or their intermediaries. This consent is subject to revocation at any time except to the extent that action has been taken in reliance on it. Withdrawal of consent shall be addressed in writing."

ASSIGNMENT OF BENEFITS :: "I authorize my health plan to pay benefits directly to STAR Physical Therapy, LLC. I understand that in the event my health plan or healthcare contract does not cover services, I will be responsible for payment. I understand that if my health plan does not consider STAR a participating provider, charges incurred will be paid by me. I further agree to accept full financial responsibility for payment of charges rendered to the above patient."

NOTICE OF PRIVACY :: "I acknowledge that a copy of the Notice of Privacy Practices is posted in the clinic and available for my review. Furthermore, I understand that I can request, and immediately receive, a copy of this document."

- I CERTIFY THAT I HAVE RECEIVED A COPY OF THIS FORM, UNDERSTAND ITS CONTENTS AND ACCEPT ITS TERMS -	
Patient / Legal Representative Signature ✕	Date:
STAR Employee Signature ✕	Date:

Patient Name:	Patient ID:
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Welcome to STAR Physical Therapy!

We work hard to stay on schedule because your time is valuable to us! Staying on schedule also allows us to provide you with the appropriate amount of time with your therapist to maximize the benefits of therapy and give you the best possible outcomes.

As a **worker's compensation patient**, we recognize that in many cases you are not working or on limited duty. More than anything, we know how much you want and need to get back to work or full duty. We are committed to doing everything we can to help!

Some important reminders regarding your scheduled appointments...

- **Obligation to Communicate** - When you cancel or miss an appointment, it's our obligation to communicate with your employer, insurance adjuster and/or case manager regarding that appointment.
- **24 Hour Notice!** - If you have to cancel an appointment, please try to provide us with at least 24 hours notice.
- **Running Late?** - Please arrive on time for your scheduled appointments. If you are running late, please call ahead and let us know.
- **15+ Minutes Late?** -If you are running more than 15 minutes late, every attempt will be made to accommodate you. Your treatment may need to be modified or rescheduled in consideration of other patients with already scheduled appointments.
- **Frequent Cancelled or Missed Appointments** - If you regularly cancel or miss your appointments, we may ask that you return to your referring physician prior to scheduling any more therapy.

Thank you for your understanding and we are looking forward to serving you!

I HAVE RECEIVED A COPY OF THE CANCELLATION & No SHOW POLICY.	
Patient / Legal Representative Signature ✕	Date:
STAR Employee Signature ✕	Date:



TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
Division of Workers' Compensation

MEDICAL WAIVER AND CONSENT

It is a crime to knowingly provide false, incomplete or misleading information to any party to a workers' compensation transaction for the purpose of committing fraud. Penalties include imprisonment, fines and denial of insurance benefits.

THIS MEDICAL AUTHORIZATION FORM ONLY PERMITS THE EMPLOYER OR THE DIVISION OF WORKERS' COMPENSATION TO OBTAIN MEDICAL INFORMATION THROUGH ORAL OR WRITTEN COMMUNICATION, INCLUDING, BUT NOT LIMITED TO, CHARTS, FILES, RECORDS, AND REPORTS IN THE POSSESSION OF A MEDICAL PROVIDER AUTHORIZED BY THE EMPLOYER PURSUANT TO T.C.A. § 50-6-204 AND A MEDICAL PROVIDER THAT IS REIMBURSED BY THE EMPLOYER FOR THE EMPLOYEE'S TREATMENT.

I, , having filed a claim for workers' compensation benefits, do hereby waive any physician-patient, psychiatrist-patient, or chiropractor-patient privilege I may have and hereby authorize

STAR Physical Therapy

(Name of Medical Provider)

to furnish to the employer (or the employer's representative, such as the insurance company) and/or the Division of Workers' Compensation any information reasonably related to my work-related injury. The authorization includes, but is not restricted to, a right to review and obtain copies of all records, x-rays, x-ray reports, medical charts, prescriptions, diagnoses, opinions and courses of treatment.

This authorization shall remain valid for 180 days following its execution. A photocopy of the authorization may be accepted in lieu of the original.

Dated: _____, 20_____.

Patient

Social Security last four numbers

Witness

Pursuant to the Rules of the Department of Labor and Workforce Development 0800-2-17.15, any physician, psychiatrist, chiropractor, podiatrist, hospital or health care provider shall, within a reasonable time, not to exceed thirty (30) days, provide the requesting party with any information or written material reasonably related to the injury for which the employee claims compensation.

INSURANCE BENEFITS (if applicable) :: As a courtesy, we will make every effort to contact your insurance company to obtain your therapy benefits. The benefit information obtained cannot be considered a guarantee of actual benefits or insurance payment for services rendered. We encourage you to contact your insurance company to verify your benefit information.

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