Evolution Physical Therapy NEW PATIENT FORM

PRINT CLEARLY

Legal Name (First)_____(Last) _____(M.I.) _____

Name Used/Preferred Pronoun _____*We will make sure to only use your "Name used" and listed pronouns in our facility.

Home Address_____

City_____State_____Zip_____

Cell Phone_____Work Phone_____Other Phone_____

Social Security_____ Birth Date_____ Age_____

Drivers License #_____Email Address_____

Legal Sex M / F *While Evolution PT recognizes a number of genders/sexes, many insurance companies and legal entities unfortunately do not. Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing, and correspondence. If your preferred name and pronouns are different from these, please let us know.

What is your gender identity?

☐ Male
☐ Female
☐ Transgender man / Transman
☐ Transgender woman / Transwoman
☐ Genderqueer / Gender nonconforming
Additional identity (fill in) _____
☐ Decline to state

What sex were you assigned at birth?

☐ Male
☐ Female
☐ Decline to state

Primary Insurance Subscriber (If different from above): (First)_____(Last) _____

Social Security #_____Date of Birth _____

Status Married / Single / Divorced / Separated / Widowed

Emergency Contact_____Telephone_____

Referring Physician_____Telephone _____

Address_____

Who may we thank for your referral other than your Doctor?_____

Employer_____**Employment** Full / Part-time / Not Working / Retired

Address_____Phone_____

Injury Type ☐ Work ☐ Auto ☐ Home ☐ Other_____Injury Date _____

Lawyer Involved Yes / No Attorney name _____

Address_____Telephone # _____

Patient Signature:_____**Date:**_____

Evolution Physical Therapy — MEDICAL HISTORY

Patient Name _____ Age _____

Type of Injury / Condition _____

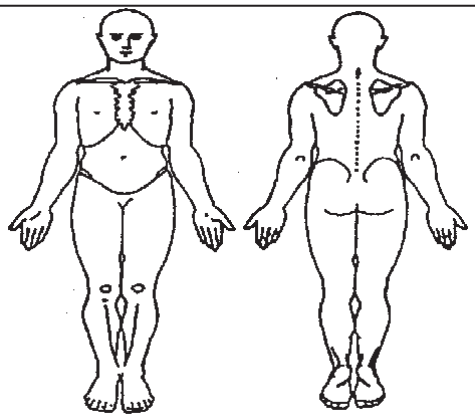
Onset / Injury Date _____

Type of Surgery & Date _____

Next Doctor's Appointment? _____

Describe previous treatment for this condition _____

_____



Please mark the area(s) of

Have you received chiropractic treatment this year? Yes / No

Have you had any imaging performed:

X-Ray
MRI
CT Scan
Doppler
Ultrasound

Have you recently noted:

Weight Loss /Gain
Weakness
Pregnant / IUD
Pain At Night
Nausea / Vomiting
Fever / Chills / Sweats
Headaches
Cramps In Legs When Walking
Fatigue
Numbness / Tingling
Change In Vision Or Hearing
Insomnia

Do you have now or have you ever had any of the following?

Surgeries
Sprains / Strains
Heart Problems
Circulation Problems / Clots
Easy Bruising / Bleeding
Indigestion / Heartburn
Loss of Consciousness
Diabetes
Cancer
Asthma / Breathing Problems
Leg / Ankle Swelling
Fainting
Fractures
Blood Pressure Problems
Motor Vehicle Accident
Lung Disease
Urinary Problems / Infections
Allergies / Skin Sensitivity

Any previous injury that may affect current care _____

Explain & give approximate dates for any items indicated above _____

_____

Are you currently taking medications? Yes / No Name or Type of Medication _____

_____

Type Of Pain: Sharp / Burning / Aching / Tingling / Numbness / Other _____

Rate your pain (1=minimal 10=severe): At it's worst: 1 2 3 4 5 6 7 8 9 10 / At it's best: 1 2 3 4 5 6 7 8 9 10

What do you hope to get out of your treatment? _____

_____

What are your physical or fitness goals: _____

_____

Is there anything else you would like to include or ask your physical therapist? _____

_____

X _____ **X** _____

Patient or Personal Representative Signature **Date**

evolution
PHYSICAL THERAPY & FITNESS

Office Policy

Consent to Treat
I consent to have Evolution Physical Therapy and/or its affiliates provide the treatment and care considered necessary and proper in diagnosing and treating my condition. I understand this consent may be revoked by me at any time. I agree that I assume all risks and responsibilities involved in participating in physical therapy through Evolution, and waive, release, and forever discharge Evolution Physical Therapy and their owners, directors, employees, or any person acting on their behalf, from all claims, demands, liability, and damages relating to, arising out of, or resulting from my participation in physical therapy provided by Evolution Physical Therapy. Patients below the age of 18 must have a legal guardian provide consent on their behalf.

Social Media Disclosure
I understand that while in Evolution Physical Therapy facilities I may be a background to a subject in social media platforms. If I am to be the subject, verbal consent will be obtained to produce content.

Workers' Compensation Claims
If you claim Workers' Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

Release of Information and Assignment of Insurance Benefits
I authorize Evolution Physical Therapy or its legal representatives to release to my insurance company or its representative any information including the diagnosis and the records of any treatment or evaluation rendered to me during the period of such care. I hereby authorize payment of medical benefits to which I am entitled to Evolution Physical Therapy for medical services rendered.

Supply Charges/Retail
We may provide treatments for which supplies are not covered by insurance. We will not bill insurance for these supplies, and the patient is responsible for related supply charges.

Credit Card Payment Fee: Be advised that all credit card transactions will be subject to a processing fee of 2.9% + $0.30 per transaction. If you choose to pay with a credit card, these fees will be automatically applied to your transaction. No additional fees for debit card/HSA/FSA transactions.

Wellness Fee
All patients will be charged a $25.00/4-weeks Wellness Fee throughout the course of their treatment. The benefits of the Wellness Fee are listed at the front desk. Patients are encouraged to continue the Wellness Fee following discharge in order to take advantage of the benefits. **To cancel, please contact our front office.**

HIPAA Private Practices
I have read and consent to the assumption of risk and release and the HIPPA practices adopted by Evolution Physical Therapy. I understand that non-identifying patient data may be used in research and/or publication and consent to such use. I understand that I may obtain a paper copy of the Evolution Physical Therapy Privacy Practices at any time by asking the Front Desk.

_____

Patient /Guardian/Responsible Party Signature **Date**