Life Strength Physical Therapy, Inc.
110 West Road, Suite 105
Towson, MD 21204
Phone 410-321-4901
Fax 410-321-4903

- **New Patient**
- **Insurance Change**
- **Address Change**
- **Change in Marital Status**

Today's Date _____
Physical Therapist _____

CONFIDENTIAL PATIENT INFORMATION

The Federal Health Insurance Portability and Accountability Act (HIPAA) established federal guidelines that require Life Strength Physical Therapy to maintain the privacy of your protected health information. The following information is required for our regular business practice and will be maintained in our private records for confidential communication.

Patient Name_____ **DOB**_____ **Sex** _____**SS#**_____
Address_____
City _____ **State** _____ **Zip** _____
Telephone (H) _____ **(W)** _____**(C)**_____
Patient E-Mail Address _____

Marital Status (Please Circle) Single Married Divorced Widowed

Emergency Contact Name:_____**Phone #:**_____

Referring Doctor Name and Phone #:_____

INSURANCE INFORMATION

Primary Insurance Company_____
Policy#_____**Group#**_____
Policy Holder_____
Relationship to patient _____ **Policy Holder's SS#**_____
Policy Holder's DOB_____ **Effective Date**_____

Secondary Insurance Company_____
Policy#_____**Group#**_____
Policy Holder_____
Relationship to patient _____ **Policy Holder's SS#**_____
Policy Holder's DOB_____ **Effective Date**_____

ASSIGNMENT OF BENEFITS: I understand that I am responsible for the accuracy of the information on this form. If for any reason payment cannot be received from my insurance company(s), I will be held directly responsible for all fees incurred with Life Strength Physical Therapy, Inc. I authorize payment of medical benefits to the provider or supplier for all services rendered if the provider of services is a participating provider with my insurance. I also authorize the release of any medical or other information necessary for the processing of claims.

AUTHORIZED SIGNATURE_____**DATE**_____

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Medical Questionnaire

Name:_____Date:_____

Medical History (circle all that apply even if medically controlled)

AIDS or HIV	Dizziness/Vertigo	Kidney Failure	Pregnant
Allergies	Fractures_____	Long Term Steroid Use	Radiation Therapy
Artificial Joint _____	Headaches	Low Blood Pressure	Seizure Disorder
Blackout Episodes	Heart Condition	Metal Implant	Stroke or TIA
Cancer	High Blood Pressure	Osteoporosis	TMJ Dysfunction
Circulatory Condition	Hyperthyroid Hypothyroid	Pacemaker	Visual Impairment
Diabetes	Incontinence	Parkinson's	

Occupation: _____

Reason(s) for which you are seeking Physical Therapy treatment:

List all prior surgeries:

List all current medications:

DRUG NAME	DOSAGE	FREQUENCY AND ROUTE
Example: Aspirin	*81 mg*	**One pill a day by mouth**

List all special tests that have been performed for your condition (i.e. X-ray, MRI, CT Scan):

List all prior physical therapy, chiropractic or osteopathic treatment for this condition:

The information I have provided is correct to the best of my knowledge.

_____ _____
Signature Date

Revised 10/19/16

lifestrength
PHYSICAL THERAPY, INC.

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PAYMENT RESPONSIBILITY WAIVER

PATIENT NAME: _____

PATIENT ADDRESS: _____

_____

(Please initial on the line next to the appropriate option.)

_____ I understand that the provider of services DOES participate with my insurance. If for some reason my insurance denies payment, I accept the responsibility for payment of charges for services.

I also acknowledge that I am responsible for payment of any copay required by my insurance at the time of service.

_____ I understand that the provider of services DOES NOT currently participate with my insurance carrier. I accept responsibility for payment of all charges at the time of service.

_____ I wish to pay for services out of pocket and to NOT have these charges submitted to my insurance carrier.

In signing this, I also acknowledge that I am responsible for notifying Life Strength Physical Therapy of any changes in my insurance.

_____ DATE: _____

PATIENT/GUARANTOR SIGNATURE

(Revised 10/17/18)

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Cancellation Policy

At Lifestrength Physical Therapy, our primary goal is to get you better as quickly as possible. You will not help your recovery if you do not make your scheduled appointments. We understand there will be reasons that are legitimate for not showing for appointments so we will be as understanding as possible.

One of the difficulties of having a successful, busy practice is scheduling all the follow up visits patients require. Please understand that when you cancel late or do not show up without notification, we may not be able to fill your scheduled appointment slot with another patient. So when patients do not arrive for their appointments it affects others who want to be seen. As a result of this situation, effective 07/05/18, patients **will be charged** for failure to make their scheduled appointments without proper cancellation notification.

We require a **minimum of 12 hours** notice or a message on our answering device before we open for the day for an appointment to be properly canceled. Earlier confirmation of a cancellation is recommended because it will allow us to possibly fill the time slot with another patient.

Charges will accrue at **$45.00 per cancellation or "no show"**. The cancellation or "no show" will be charged to the patient's account, not to the insurance company. Subsequent failures to abide by this policy will also be charged. We will consider any reasonable excuse given by the patient to justify the late cancellation or "no show".

After three "no shows" or a pattern of late cancellations, you will no longer be allowed to schedule in advance and will have to call in the morning to be worked in if possible. We regret that we have to institute this change in policy. We appreciate your understanding and thank you for choosing us for your rehabilitation.

Patient or Responsible Party	Signature	Date

(10/16/18)