

NEW PATIENT INTRODUCTORY PAPERWORK

Name:	Date of Birth:	Nickname:		
Mailing Address:				
Street Address: (If different the	an above)			
Home Phone:	Cell Phone:			
What phone number is the be	est for contacting you? HOME / CELL /	OTHER:		
Email Address:				
Emergency Contact Name:	Relationship:	Phone #:		
Social Security #:	Referring Physician	Referring Physician:		
Insurance Type:	Subscriber: (If not p	Subscriber: (If not patient include SSN and DOB)		
What are your goals for physic	PT/OT. Please include their name and cal therapy?	relationship to you.		
	nformation you would like the therapist	to know regarding your visit?		
Signature:		_ Date:		
BILTMORE		NTON ENKA-CANDLER 0 E 828-692-1481 E 828-633-6287 E 828-633-		

FAIRVIEW P: 828-338-0707 F: 828-338-0708

P: 82

N. ASHEVILLE

P: 828-785-1412 F: 828-785-1413

WAYNESVILLE P: 828-246-6566 F: 828-246-6567 288

WEAVERVILLE P: 828-484-9415 F: 828-484-9478

WWW.SEPTPHYSICALTHERAPY.COM



MEDICAL SCREENING FORM

Name:	DOB/AGE:	Gender:			
Current Issue:		_ Date of Injury:			
Recent Surgery:		_ Date of Surgery:			
Are you currently: Student	working not working	Occupation:			
retired	other:	-			
Sports:	School:	Grade:			
Housing: house apartment condo mobile home other:					
Do you have stairs?yes] no A railing? yes no	Steep lot? yes no			
Please rate your general health: excellent good fair poor					
Any allergies? yes no Please Explain:					
Past surgeries/injuries/hospitalizations:					
Have you Ever been diagnosed with any of the following conditions? (check all that apply)					
ancer rheumatoid arthritis diabetes other arthritis high blood pressure					
depression heart problems tuberculosis stroke bone/joint infection					
HIV hepatitis asthma COPD chemical dependency seizures					
blood clots other:					
Please check any that apply to ye Osteoporosis Pins or N		Pacemaker Pregnant			
Any significant family medical hist	cory?				

 BILTMORE
 BLACK MOUNTAIN

 P: 828-412-5330
 F: 828-412-5329
 P: 828-357-9050
 F: 828-357-9051
 P: 828-492

 FAIRVIEW
 N. ASHEVILLE

CANTON P: 828-492-1480 F: 828-492-1481 ENKA-CANDLER P: 828-633-6287 F: 828-633-6288

FAIRVIEW R: Adheville P: 828-338-0707 F: 828-338-0708 P: 828-785-1412 F: 828-785-1413 WAYNESVILLE P: 828-246-6566 F: 828-246-6567

WEAVERVILLE P: 828-484-9415 F: 828-484-9478



MEDICAL SCREENING FORM

BILTMORE BLACK MOUNTAIN 28-412-5330 F: 828-412-5329 P: 828-357-9050 F: 828-357-9050 FAIRVIEW N. ASHEVILLE 28-338-0707 F: 828-338-0708 P: 828-785-1412 F: 828-785-1412	w	CANTON 1480 F: 828-492-1481 AYNESVILLE 5566 F: 828-246-6567	ENKA-CANDLER P: 828-633-6287 F: 828-633-6288 WEAVERVILLE
Signature:		Date:	
What makes it worse?	What makes	s it better?	
Circle your worst pain level during the past 24	hours: 1 2 [3 4 5 6	7 8 9 10
Circle your best pain level during the past 24		3 4 5 6	
Your current level of pain while completing thi	s survey: 🗌 1 🔲 2 [3 4 5 6	7 8 9 10
Using the 0 to 10 scale, with 0 being "no pain"	and 10 the "worst po	ain imaginable" des	cribe:
Any previous treatment for the current issue?			
Have you had similar issues previous to this?			
Any imaging performed?			
CURRENT SYMPTOMS:	WHEN STARTED:	HOW STARTED:	
MEDICATION: (Provide copy of list if possible)	REASON:	DOSAC	ЭЕ:

WWW.SEPTPHYSICALTHERAPY.COM

P: 8

P: 8



PATIENT CONSENT FORM

PATIENT CONSENTS:

(initial) I consent to be evaluated and treated by SEPT Physical Therapy by a licensed physical therapist, physical therapist assistant, or an occupational therapist.

(initial) ____ I grant permission to SEPT Physical Therapy to release my medical records to any outside vendors for the purpose of obtaining equipment to aide in my physical therapy treatment.

(initial) **_____PAYMENT AUTHORIZATION & ASSIGNMENT:** I hereby authorize this physician/clinic to release any information required in the course of my examination or treatment to other healthcare providers. In the case of Medicare, I authorize the release to the Health Care Financing Administration and its agent any information needed to determine benefits payable for related services. I authorize direct assignment of my benefits payable under my insurance to this facility.

FINANCIAL RESPONSIBILITY:

I understand that I am responsible for any amounts not covered by my insurance company. I understand that services received at SEPT Physical Therapy are billed in a clinical setting intended for physical therapy services. This may affect how my insurance pays and any relating pre-certification, co-pay, co-insurance, out-of-pocket amount, or deductible. SEPT Physical Therapy recommends for you to contact your insurance company to verify coverage, including visit limits and/or pre-certification requirements.

<u>Co-pays are due at time of service</u>. If you cannot afford to pay your co-pay at each visit, you may fill out a payment plan and pay an amount that you can afford on a monthly basis. If you would like to set up a payment plan, please let us know and we will be happy to assist you with this.

Patient or Guardian Signature Date **Employee Witness** BILTMORE **BLACK MOUNTAIN** CANTON ENKA-CANDLER P: 828-412-5330 F: 828-412-5329 P: 828-492-1480 F: 828-492-1481 P: 828-633-6287 F: 828-633-6288 P: 828-357-9050 F: 828-357-9051 N. ASHEVILLE WAYNESVILLE FAIRVIEW WEAVERVILLE P: 828-785-1412 F: 828-785-1413 P: 828-246-6566 F: 828-246-6567 P: 828-338-0707 F: 828-338-0708 P: 828-484-9415 F: 828-484-9478

WWW.SEPTPHYSICALTHERAPY.COM



PATIENT CONSENT FORM

PRIVACY PRACTICES:

SEPT Physical Therapy cares about your privacy. SEPT Physical Therapy is committed to protecting your medical information. We do create a record of your treatment to provide you with outstanding care and compliance with legal documentation. We may utilize this information to provide you with your medical care, or to disclose to bill and receive payment for the services we render; or for the pre-authorization needed for your services. We may release information requested by your workers compensation (wc) carrier, wc nurse, or wc claim adjuster, as well as in response to any court order, subpoena, warrant, summons or similar process. We may also use this information to contact you with appointment reminders or to tell you about possible alternative treatment options that may be of interest to you. You also have the right to inspect and/or receive your medical information that may be released to above mentioned parties. A written request is required to release your information to yourself or anyone you have authorized. A fee may be incurred for the information requested. Anyone listed as a responsible party on your paperwork is able to request your information. You have a right to submit a written restriction or limitation on your account on information that is disclosed. In this request you must list what information is limited and to whom it is to apply. If you believe your privacy has been violated please contact our Operations Director at 828-274-2188. We will try to accommodate all reasonable requests.

Patient Signature or Legal Representative **Patient Printed Name**

Date

TO BE SIGNED IF PATIENT IS UNDER 18 YEARS OF AGE:

We encourage parent involvement in treatment; however, please sign below if the patient is under the age of 18 and you give consent for SEPT Physical Therapy to treat your child in the absence of a parent/guardian.

Parent/Guardian Signature

Date

BILTMORE P: 828-412-5330 F: 828-412-5329 BLACK MOUNTAIN P: 828-357-9050 F: 828-357-9051 N. ASHEVILLE CANTON P: 828-492-1480 F: 828-492-1481 ENKA-CANDLER P: 828-633-6287 F: 828-633-6288

FAIRVIEW P: 828-338-0707 F: 828-338-0708
 N. ASHEVILLE
 WAYNESVILLE

 P: 828-785-1412
 F: 828-785-1413
 P: 828-246-6566
 F: 828-246-6567

WEAVERVILLE P: 828-484-9415 F: 828-484-9478

WWW.SEPTPHYSICALTHERAPY.COM



MISSED APPOINTMENT POLICY & APPOINTMENT REMINDERS

SEPT Physical Therapy is committed to your well-being and recovery. Your adherence to the plan established by your therapist is vital to your treatment. Non-adherence to your physical therapy plan may result in delayed recovery.

Patient Name:

_____ Date of Birth: ____

24-Hour Notice of a cancelled appointment allows us the opportunity to offer that time slot to another patient who may be in need of treatment. For this reason we have implemented the following Missed Appointment Policy:

- 1. We require 24-hour notice for any appointment cancellations (we understand there may be times when this is not possible due to unforeseen circumstances, but please provide 24-hour notice whenever feasible).
- **2.** A total of 3 cancellations or 2 no-shows without 24-hour notice may result in discontinued treatment.
- **3.** We reserve the right to notify your physician of any non-compliance issue regarding your attendance.

Please select how you would like to be reminded of your upcoming appointments:

_____ Text

____ Phone Call

____ Email

Please sign and date below indicating you have read, understand, and agree to the Missed Appointment Policy, and that you agree to receive appointment reminders via the method you have selected.

Patient/Guarantor	Signature	Date		
Employee Sigr	nature	Date		
			Serving Western North	Carolina since 1999.
BILTMORE 828-412-5330 F: 828-412-5329	BLACK MOUNTAIN P: 828-357-9050 F: 828-357-9051		CANTON P: 828-492-1480 F: 828-492-1481	ENKA-CANDLER P: 828-633-6287 F: 828-633-62
FAIRVIEW 828-338-0707 F: 828-338-0708	N. ASHEVILLE P: 828-785-1412 F: 828-785-1413		WAYNESVILLE P: 828-246-6566 F: 828-246-6567	WEAVERVILLE P: 828-484-9415 F: 828-484-94