Family/Referring Doctor_____

Patient Email address_____

FIFE THERAPY

Physical Information & Medical History Form

Name_____DOB_____ SEX ___ SSN# _____

Address _____ CITY _____ STATE ____ Zip Code _____

Phone _____ Occupation _____ Employer _____

Emergency Contact _____ Phone_____ _____Email_____

Reasons for therapy_____

When/How did symptoms start_____

_____

Past Medical History Height _____ WT _____

____ Diabetes ___Rheumatoid ___ High Blood Pressure ___ Low Blood Pressure___ Kidney Problems ----- Heart Problems

___Hepatitis ___Hypoglycemia ___ Cancer ___ Fibromyalgia ___ Lung Problems ___ Vascular Problems

___ Arthritis ___ Other _____

Please List any allergies_____

Please list meds with mg_____

_____

_____

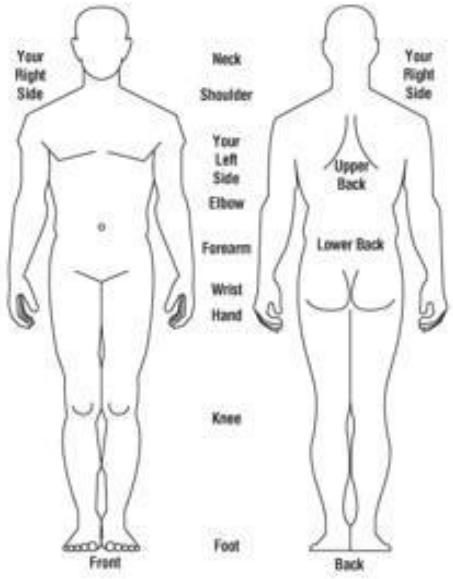
Past Surgeries_____

_____

Pain 1-10, 0= no pain 10= Worst Imaginable Pain

Now ___/10
Lowest pain level ___/10
Highest pain level ___/10

Please indicate **your** complaint area



Patients Signature _____

Date _____

Therapists Signature_____

Date_____

Thank You for Completing this form!

Patient Authorization Record

Initial here	
	Authorization for Treatment I hereby give authorization for the performance of such rehabilitation procedures as permitted by *Georgia* Statutes under the appropriate scope of practice are, in the judgment of my Therapist, deemed necessary, which can include a Deep Tissue Laser treatment.
	Authorization for Release of Information I agree that FIFE THERAPY may provide information from my medical record to persons involved in my medical care. I authorize the release of medical information necessary to obtain payment of any benefits available to me to FIFE THERAPY for services rendered. I agree that FIFE THERAPY may obtain information from others who have provided medical care to me and/or are responsible for the payment of all or part of my bills when this information is needed in order to treat, bill, and/or receive payment. I have read "Notice of Privacy Practices" mandated by HIPAA.
	Authorization for Release of Payment I authorize that direct payment of any benefits available to me be released to FIFE THERAPY for services rendered.
	Patient Agreement I agree to pay *FIFE THERAPY* charges for services rendered to me during my course of treatment. I agree to pay those charges which may not be paid by my health insurance and are my responsibility per my insurance benefit. If I do not pay for charges that are my responsibility, I agree to pay *FIFE THERAPY* collections costs including attorney and court fees.
	Medicare, Medicaid, and Similar Benefits I agree that the information given to *FIFE THERAPY* in applying for benefits under Medicare, Medicaid, and Maternal or Child Health services are complete and accurate. I agree that *FIFE THERAPY* may give Social Security Administration or its fiscal intermediary's information necessary to process claims.
	Workers Compensation I agree that the information given to *FIFE THERAPY* in applying for benefits under Workers Compensation is complete and accurate. I agree that *FIFE THERAPY* may give intermediary's information necessary to process claims.

_____

Patient signature Date

_____

Printed patient name Witness Signature Date

_____ Signature of Legal Representative/POA

Cancellation and No Show Policy

We are fully committed to your recovery at FIFE THERAPY and compliance to our program is very important to us. We will attempt to reschedule your appointment as soon as there is an opening, but because we commit to one on one therapy previously scheduled appointments from other patients will have priority.

FIFE THERAPY requires 24-hour advance notice for any cancellation. If you are unable to give 24-hour advance notice you will be charged a $30.00 fee. **If you do not show up for your scheduled appointment** an administrative fee of **$45.00 will be charged** to your card that you provide on the following page. Please also be aware that in the event you do not show up for an appointment, we may not be able to continue treating you as a patient. Thank you.

I, _____ have read the above stated policy and agree to be responsible for my health and for any fee associated with my inability to adhere to this policy.

_____ ___/___/_____
Patient signature Date

Only complete if you have **TRICARE INSURANCE**

Tricare Sponsor Name:_____ Sponsor DOB:_____/_____/_____

Tricare Sponsor SSN/ID:_____ Relationship to Sponsor:_____

Select one Tricare: PRIME SELECT RETIRED OTHER_____

Known Copay amount:_____

Please be informed that FIFE THERAPY collects all known co-pays, co-insurances or deductibles at the time of your visit. Please be advised this card will also be used in the event that you are charged a day of cancelation fee of $30.00 or a "No show" fee of $45.00 (Please refer to previous form for any questions regarding this fee). Thank you.

Fife Therapy requires a form of payment to be kept on file, either Credit card, Debit Card or HSA.

____Credit ____Debit ____ HSA (Health Savings Account)

____ Visa ____ MasterCard _____ American Express_____ other

Name on Card: _____

Credit Card #: _____Exp Date:____/_____CSC: ____

Billing Address: _____

_____

I,_____, authorize this card to be used for all Copay's, Co-Insurance, or deductibles at Fife Therapy, and I am aware this card will be charged in the event that I don't give a 24Hour notice of cancelation, or in the event that I don't show up for a scheduled appointment, which is a $45.00 charge.

Signature: _____Date ____/____/_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____ have read and been offered a copy of this office's Notice of Privacy Practices

_____

Print Name

_____

Signature Date

_____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because;

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐
- ☐

An emergency situation prevented us from obtaining acknowledgement

Other (please specify_____

_____