



THERAPY SERVICES

www.appletherapy.com

Appt. Date _____

Appt. Time _____

Therapist _____

PATIENT INFO

Last Name _____ First _____ MI _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security # _____ Date of Birth _____ Age _____

Employer _____

Address _____ City _____ State _____ Zip _____

Occupation _____ Post Op. Y / N _____ DIAG _____

Primary Care Physician _____ **Referring Physician** _____

Date of Injury _____ Date Last Seen by Referring Physician _____

Spouse's Name _____ Employer _____

Have you had **PT/OT/ST** prior this year? **Y / N** If Yes, When: _____ Please call your insurance and confirm what your remaining benefit is. Insurance companies **WILL NOT** provide us with this information. Let us know by **YOUR NEXT APPOINTMENT**.

BILLING INFORMATION Medical Ins _____ Motor Vehicle _____ Work Comp _____ Other _____

• **Health Insurance** (Subscriber information please)

Insurance Co. _____

Insurance Subscriber _____ DOB _____

Social Security # _____ Employer _____

• **Worker's Comp / MVA / Liability** (Please circle one)

Insurance Co. _____ Address _____

City _____ State _____ Zip Code _____

Telephone _____ Claim # _____

Adjustor _____ Nurse Case Mgr. _____

• **Attorney** (If there is a legal case pending, please furnish the name & address of your attorney as well as a letter of protection.)

Name _____ Address _____

City _____ State _____ Zip Code _____

Telephone _____ Misc. Information _____

RESPONSIBLE PARTY INFORMATION (If patient is under 18 years of age)

Name of Responsible Party _____ SS# _____ DOB _____

Employer _____ Work Phone _____

I (_____) give permission to Apple Therapy Services to treat my child that would include any modalities that the doctor may prescribe.



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RISK PROFILE

- 1. Do you smoke? _____ If so, how many packs per day? _____
- 2. Is your occupation stressful? _____
- 3. Is your occupation physically: _____ Sedentary _____ Moderately Active _____ Very Active _____
- 4. Are you taking any medications? _____ If so, please list: _____
- 5. Do you currently exercise on a regular basis? _____
- 6. If female, are you currently pregnant? _____ How far along? _____

MEDICAL HISTORY (If yes, please check)

Past History

- Asthma ()
- Cancer ()
- Diabetes ()
- Epilepsy/Seizures ()
- Heart Trouble ()
- High Blood Pressure ()
- Hypoglycemia ()
- Injuries to Knees or Ankles ()
- Lung Disease of Arteries ()
- Rheumatic Fever ()
- Rhythm Abnormalities ()
- Stroke, Heart Attacks ()
- Varicose Veins ()
- Operations: _____
- Other: _____

Present Symptoms

- Awaken Short of Breath ()
- Arthritis ()
- Back Pain ()
- Chest Pains ()
- Cough on Exertion ()
- Cough up Blood ()
- Heart Palpitations ()
- Light Headedness ()
- Loss of Consciousness ()
- Shortness of Breath ()
- Swollen Legs ()
- Use more than one pillow for sleep
- Allergies _____
- Other _____

FAMILY HISTORY

Have any of your blood relatives (parents, sisters, brothers) had/have:

- Cancer ()
- Heart Attacks ()
- High Blood Pressure ()
- Heart Operations ()
- Congenital Heart Disease ()
- Diabetes ()
- High Cholesterol ()
- Other _____

I give permission to Apple Therapy Services to render treatment as needed.

Signature _____ Date _____

RECORDS RELEASE

I give permission to Apple Therapy Services to release my therapy records to my physician, insurance company, or other related parties (i.e. case nurse).

Signature _____ Date _____

I give consent to release any medical records to Apple Therapy Services that is necessary to aid in my treatment.

Signature _____ Date _____

I have received a copy of the Patient Bill of Rights _____
Signature _____ Date _____

I have received a copy of the Privacy Notice Policy _____
Signature _____ Date _____



CANCELLATION POLICY

We, at Apple Therapy Services, will make every effort to schedule your therapy appointments at a time that is convenient for you. **In the event that you cannot attend a particular scheduled appointment, we ask that you call Apple Therapy Services (preferable 12 to 24 hours) prior to that appointment to cancel and/or reschedule the appointment. If you do not call to cancel and do not show up for a scheduled appointment, you could be charged for a missed appointment.**

If you miss 3 scheduled appointments, we reserve the right to discharge you from therapy. In order to resume therapy after such time, you will need to see your physician, obtain another prescription and call us to schedule a re-evaluation.

Also, if you are more than **15 minutes late for your appointment**, it will be left to the discretion of the therapist whether or not you will be treated at that time.

If you have any questions about this policy, please do not hesitate to ask. Thank you in advance for your cooperation.

Patient
Signature _____ **Date** _____

STATEMENT OF ULTIMATE RESPONSIBILITY

I understand that Apple Therapy Services will, as a courtesy to me, bill my insurance company for services rendered and send a monthly statement to me. I also give permission to release any medical information necessary to said insurance company.

I understand that if services rendered from the initial visit to present are non-referred/non-covered services, I will be responsible for payment. I accept full responsibility for all services that have not been authorized by my physician or insurance company.

I agree to pay my balance with Apple Therapy Services if either my Worker's Compensation claim is denied, my MedPay / PIP is exhausted, my private health insurance does not cover services or if my legal case is not settled in my favor.

I also understand that I am ultimately responsible for any balance on this account. Any patient balance over 90 days is subject to a 10% late fee. Account balances over 120 days will be sent to collection.

I agree to set up a monthly budget fee payment schedule in the event there is a balance on this account after insurance payments or legal case settlements.

I authorize payment of all claim forms directly to Apple Therapy Services.

I understand that if my health plan has a copay option, I am responsible to pay at time of service.

Patient
Signature _____ **Date** _____