Carol Frazier & Associates Physical Therapy
22 West Road, Suite 302
Towson, Maryland 21204

PERSONAL INFORMATION & PATIENT REGISTRATION

Date: _____ **Referring Physician**_____

Name (Last, First, Middle) _____

Address_____

City_____ **State**_____ **Zip Code**_____

Email Address_____

Home Phone_____ **Cell/Mobile Phone**_____

Date of Birth_____

Emergency Contact: _____**Phone**_____

Relationship to patient: _____

_____

FOR PATIENTS UNDER 18 YEARS OF AGE:

Responsible Party Name_____

Responsible PartyAddress_____

City_____**State**_____ **Zip Code**_____

_____

FOR OUR MEDICARE PATIENTS:
2022 Deductible: $233

Have YOU had <u>any</u> physical therapy services this year? YES NO

Have YOU had <u>any</u> home health services within the past several weeks? YES NO

You are responsible for knowing the particulars of your insurance benefits.

We expect payment of any deductible, copay, or coinsurance portion *at the time of each visit.*

Carol Frazier & Associates Physical Therapy
22 West Road, Suite 302
Towson, Maryland 21204

RELEASE FORM AND FINANCIAL AGREEMENT

I hereby authorize **Carol Bedwell Frazier, P.T., P.A.**, to release medical information pertaining to my medical treatment as requested by my health insurance or legal counsel for billing purposes.

I hereby authorize payment directly to **Carol Bedwell Frazier, P.T., P.A.** of the outpatient physical therapy benefits herein specified and otherwise payable to me.

There will be a $10 Administrative Fee added to each account, once per year. Please ask our staff any questions that you may have.

There will be a $35 service fee for any returned check, in addition to other remedies provided by law.

A $75 MISSED APPOINTMENT FEE may be charged if an appointment is missed without prior notice given to our office.

In consideration of the acceptance as a patient of the below-named individual by **Carol Bedwell Frazier, P.T., P.A.** and of the services rendered and/or to be rendered him/her as a patient, the undersigned hereby guarantees payment of any and all charges made by **Carol Bedwell Frazier, P.T., P.A.** for the services, and authorizes an officer of the professional association to give evidence of the indebtedness. I agree that if I do not pay such charges within thirty (30) days of demand therefore, I will pay interest in the amount of 2% per month until the unpaid charges are paid in full. Further, if the unpaid charges are referred to a collection agency for collection, I will pay collection costs of $25.00 or twenty-five (25%) percent of the amount due, whichever is greater. In addition, if the account is referred to an attorney for suit to collect the unpaid charges due, I will pay One Hundred Fifty ($150.00) Dollars or thirty-five (35%) percent of the amount that is due, whichever is greater. I acknowledge that this contract is under seal and is therefore subject to the twelve (12) year statute of limitations.

CONSENT FOR TREATMENT

By signing this Consent for Treatment, I hereby authorize Carol Frazier & Associates Physical Therapy and the healthcare providers therein consent to perform assessment and treatment procedures deemed medically necessary for me (or minor patient) related to diagnosis.

PATIENT/GUARANTOR SIGNATURE_____**(SEAL)**

PRINT NAME_____**DATE**_____

Carol Frazier & Associates Physical Therapy

Current Medical Condition

Name: _____ **Date:** _____ **Date of Birth:** _____

Referring Physician: _____ **Primary Care Physician:** _____

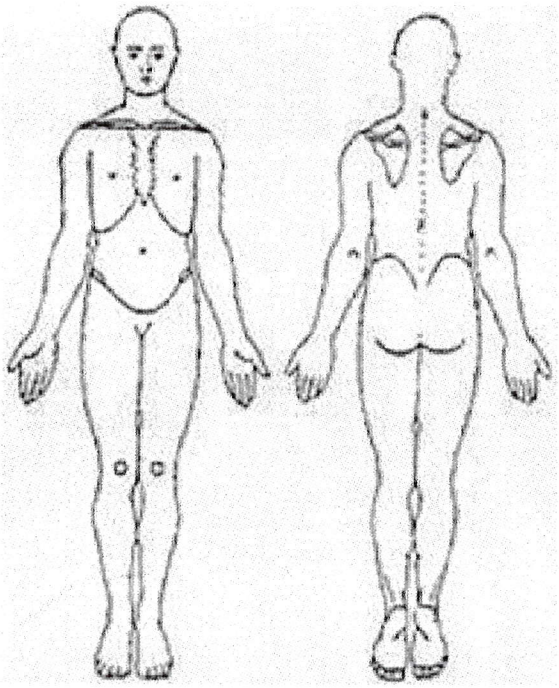
Problem bringing you to therapy today: _____

When did this issue begin? _____

If chronic, when did this particular episode begin? _____

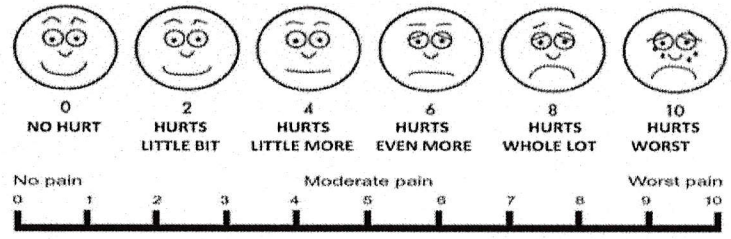
Is it a result of an activity, position or injury, and if so, what? _____

What activities or positions make your symptoms worse? _____

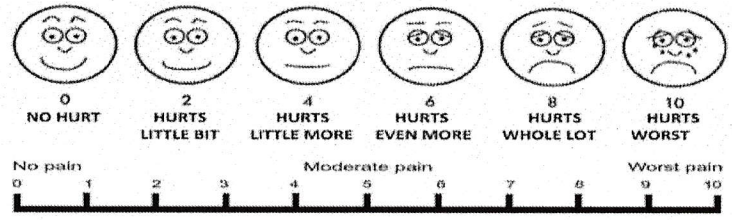


Please Color in the Areas of your Symptoms

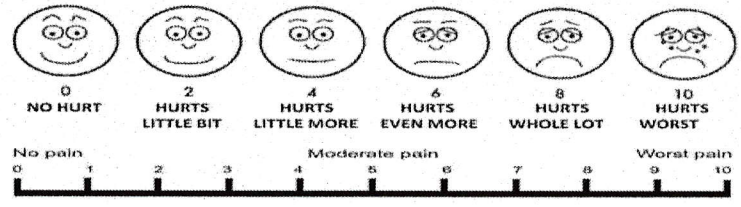
CURRENTLY: **Please Rate Your Pain:**



AT YOUR WORST:



AT YOUR BEST:



Carol Frazier & Associates Physical Therapy

Medical History

Name: Last_____ First _____ MI ____ **Date of birth**: _____

Who referred you? _____ **Are you**: □ Right-handed □ Left-handed

Employment/Work (Job/School/Play)

□ Working full-time outside of home □Working full time from home
□ Working part-time outside of home □ Working part-time from home
□ Homemaker □ Student □Retired □Unemployed
Occupation: _____

General Health Status: Please rate your health:

□ Excellent □ Good □Fair □Poor

Have you had any major life changes during the past year, such as a new baby, job change, or death of a family member? Yes ____ No _____

Social/Health Habits:

□ Exercise: Do you exercise beyond normal daily activities and chores? Yes or No
Yes? Describe the exercise_____

On average, how many days per weeks do you exercise? _____

For how many minutes on average? _____

Medical/Surgical History

Please check if you have ever had:

□ Arthritis
□ Blood Disorders
□ High blood pressure
□ Diabetes/high blood sugar
□ Multiple sclerosis
□ Seizures/epilepsy
□ Thyroid problems
□ Kidney problems
□ Ulcers/stomach problems
□ Broken bones/fractures
□ Circulation/vascular problems
□ Lung problems
□ Head injury
□ Muscular dystrophy
□ Allergies
□ Infection disease
□ Repeated infections
□ Osteoporosis
□ Heart Problems
□ Stroke
□ Low blood sugar/hypoglycemia
□ Parkinson disease
□ Developmental or growth problems
□ Cancer
□ Skin diseases
□ Depression
□ Other_____

Within the past year have you had any of the following symptoms:

□ Chest pain
□ Loss of appetite
□ Hoarseness
□ Shortness of breath
□ Coordination problems
□ Weakness in arms or legs
□ Difficulty walking
□ Vision problems
□ Difficulty sleeping
□ Cough
□ Difficulty swallowing
□ Dizziness or blackouts
□ Urinary problems
□ Loss of balance
□ Hearing problems
□ Pain at night
□ Heart palpitations
□ Nausea/vomiting
□ Bowel problems
□ Weight loss/gain
□ Headaches
□ Fever/chills/sweats
□ Joint pain or swelling
□ Other _____

Have you ever had surgery? □ Yes □ No
If yes, please describe, and include dates:

_____ Month_____ Year_____
_____ Month_____ Year_____
_____ Month_____ Year_____

Current Medications List

Name: _____

Prescription Medications and Over-The-Counter Drugs/Supplements:

Name of Medication	Strength and Frequency	How is Medication Taken (Oral, Rectal, Transdermal)	Reason for Medication

Date & Initial: _____ _____ _____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____ _____ _____