Grassroots Physical Therapy, LLC
Client Information Form

Name:_____Birthday:_____ Age:___
Address:_____City:_____State:___Zip:_____
Phone:_____ e-mail:_____
Referred By:_____
Emergency Contact (name and phone number):_____
Please list any allergies you have:_____
Best Way to Reach You: Phone Text E-mail

Consent to communicate by E-mail: Communication by e-mail, including scheduling your appointments through our website, is inherently insecure and we do not currently use an encrypted email service. Additionally, there is no expectation of privacy if you use a work email address. Therefore, if you choose to communicate with us by email or schedule your appointments through our website, you are agreeing to assume the risk that the communication may be intercepted, altered, forwarded and/or read by an unauthorized third party. If you consent to email communication, we will use it only to communicate with you only about non-sensitive and non-urgent issues such as routine follow-up questions and appointment scheduling. All e-mails to or from you will be made a part of your medical record. You will have the same right of access to such e-mails as you do to the remainder of your medical file.

- I understand the risks of communicating by e-mail and consent to email communication. I understand that GRPT cannot guarantee the security and confidentiality of e-mail communication and will not be responsible for messages that are not received or delivered due to technical failure, or for disclosure of confidential information unless caused by intentional misconduct.

Please check any of the following whose care you are under

__Medical Doctor __Psychiatrist/Psychologist Other_____
__Osteopath __Physical Therapist _____
__Dentist __Chiropractor

If you have seen any of the above during the past three months, please describe for what reason:

_____
_____

Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason.

1._____ 2._____
3._____ 4._____
5._____ 6._____

Please describe any significant injuries for which you have been treated (including sprains, dislocations and fractures) and the approximate date of injury.

1._____ 2._____
3._____ 4._____
5._____ 6._____

Have you EVER been diagnosed as having any of the following conditions?

YES NO Cancer, if YES please describe what kind:_____

YES NO Heart Problems	YES NO High Blood Pressure
YES NO Circulation Problems	YES NO Asthma
YES NO Emphysema/Bronchitis	YES NO Chemical Dependency (i.e. alcohol, drugs)
YES NO Thyroid Problems	YES NO Diabetes
YES NO Multiple Sclerosis	YES NO Fibromyalgia, Chronic Fatigue, and/or IBS
YES NO Rheumatoid Arthritis	YES NO Other Arthritic Conditions
YES NO Depression	YES NO Hepatitis
YES NO Tuberculosis	YES NO Stroke
YES NO Kidney Disease	YES NO Anemia
YES NO Auto Immune Disease	YES NO Epilepsy
YES NO Osteoporosis/Osteopenia	YES NO Other:_____

Please list any prescriptions you are currently taking.

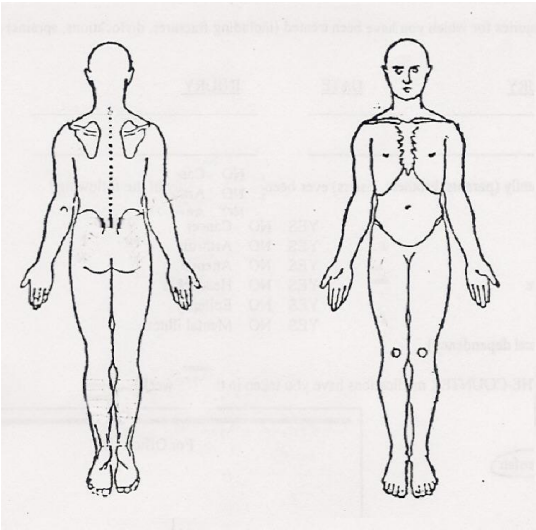
_____

Please list all Over-The-Counter medications, vitamins and herbal supplements you have taken in the past week.

_____

If you are pregnant, what is your due date:_____

Mark on the diagram where your pain is.



On a scale from 0 to 10 rate your pain when it is at its
Best:_____Worst:_____
Has your condition been getting BETTER or WORSE

Describe the type of pain you are experiencing:

_____

When do you experience the pain:

_____

What activities alleviate your pain:

_____

What activities aggravate your pain:

_____

Are you currently participating in a regular exercise routine? YES NO If YES, what are you doing?

_____

Have you had physical therapy for this condition? YES NO If YES, what were the results?

_____

What are your goals and expectations from physical therapy?

_____

Payment Agreement

- You agree to be financially responsible for all charges regardless of any applicable insurance or benefit payments, third-party interest, or the resolution of any legal action or lawsuits in which you may be involved.
- Payment is expected at time of service unless you have made other payment arrangements with us.
- **Out-of-Network Policy.** (Does not apply to Medicare) If we are out-of-network with your health plan and you have out-of-network benefits, we will provide you with a copy of your bill that you can, at your discretion, submit to your health plan for reimbursement for the services your health plan covers.
- **Medicare Policy.** If you are a Medicare beneficiary, you understand that our licensed physical therapists are ***not*** enrolled as a Medicare providers. Medicare has onerous technical and administrative requirements that must be met for services to be considered medically necessary covered benefits. We believe those requirements take unnecessary time away from the services we provide. Since our services are not designed to meet Medicare's covered benefit requirements and we are not Medicare enrolled providers, our services will not be covered (paid) in full or in part, by Medicare (including Medicare Advantage Plans) even if the same services might be considered covered benefits when provided by a Medicare enrolled provider. We will not submit claims to Medicare on your behalf or provide you with a statement or billing codes that you can submit to Medicare yourself. If you want Medicare to pay for any services that might be considered covered benefits, you should seek those services from a Medicare enrolled provider. By choosing to receive our services after being fully informed of these facts, you are agreeing to pay privately for the services you receive from us even if those services might be covered by Medicare if provided by a Medicare enrolled provider. You also understand that since we are not enrolled Medicare providers and our services do not meet the technical requirements for Medicare covered benefits, our services are ***not*** subject to Medicare's maximum allowable charge. You agree that you, your caregivers, family members, authorized representatives or power of attorney will not, under any circumstance, submit our claims, invoices, receipts or statements to Medicare or your Medicare Advantage Plan for reimbursement or to obtain a denial for a Medicare supplemental insurance plan.

Appeals Policy. You understand that you are responsible for filing all appeals of adverse benefit determinations. Upon receiving a denial for payment, in whole or in part, we will bill you for our services and you will be personally responsible for whatever fees your health plan does not cover. If you need assistance filing an appeal with your health plan, contact the consumer assistance agency on your denial letter.

Cancellation Policy

In order to allow clients at Grassroots Physical Therapy to receive the services we provide, we request a 24-hour notice of cancellation prior to the time of your appointment. If proper notice is not given, you will be billed the full amount of your visit.

I, the patient/ patient's legal representative, hereby declare that all the information provided above is accurate to the best of my knowledge.

Signature_____Date_____