PT UNLIMITED, INC

First Name:	Middle Initial:	Last Name:
DOB:	Phone:	Email:
Work Status: Full-Time Part-time Homemaker Student Retired Disability MD- prescribed work duty restriction:		
Height:	Weight:	

Emergency Contact Name/Relationship:	Phone:
GOALS to achieve in PT:	

PLEASE CHECK YES OR NO.

CIRCLE CONDITION IF MUTIPLE CHOICES IN SAME ROW

N	Y		N	Y		N	Y	
		***Cancer ***			*Cardiac Disease *			**Pacemaker**
		Clot/Emboli			Epilepsy			Seizures
		Diabetes			Asthma/Emphysema/COPD			Osteoarthritis
		Rheumatoid Arthritis			Osteoporosis			Osteopenia
		Concussion			CVA/Stroke/Brain Injury			Parkinson's
		Pregnant Currently			Anxiety / Depression			Fibromyalgia
		Celiac, Crohn's, IBS			Thyroid Disease			Vestibular/Balance Disorder
		Hernia			Smoker			*Metal*(eg: Hip, knee, shldr, rod(s))
		Allergies			*Car Accidents*			*Surgeries*

Please describe ***answers*** from above / Include other conditions, etc. not listed above
(Please include dates where applicable):

Please list current medications & / or supplements *(can provide list for records):*

X_____ / / / **in meds**

X_____ / / / **in meds**

PT Unlimited, Inc
4146 Library Rd
Suite 1A
Pgh, PA 15234

CONSENT TO TREATMENT

PATIENT NAME: _____ **DATE OF BIRTH**: _____

__ I authorize and consent to physical therapy services which are necessary or beneficial.

__ I understand that the practice of medicine is not an exact science and I acknowledge that no guarantees are made as to the results of the procedures performed or treatments received by physical therapists of **PT Unlimited, Inc**. .

__ I consent to the release of all information from the medical record to the government, utilization review and accrediting agencies having responsibility for the oversight of healthcare providers.

__ I consent to the photographing or videotaping of evaluation and treatment procedures to be performed. To the extent that such photographs and/or videotapes are for scientific or educational purposes only, I understand that the photographs will not become part of my/the patient's medical record.

__ I consent to treatment at this facility. I understand that I may choose among providers of care and can opt to receive therapy services at/by another facility.

__ I have read this form (or have had it read to me) in its entirety, have had any questions answered to my satisfaction and am signing this form knowingly and voluntarily.

Consent to Evaluation and Treatment:

By my signature below, I certify that the information I have provided is complete, accurate and truthful to the best of my knowledge, and I consent to the evaluation and treatment of my condition by **PT Unlimited, Inc** licensed physical therapists.

_____ _____

Patient signature/responsible party signature **Date**

_____ _____

Witness/PT Unlimited, Inc. employee signature Date

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AUTHORIZATION TO RELEASE INFORMATION/ASSIGN BENEFITS

Patient Name: _____ Date of Birth: _____
Start of care date: _____

I consent to the release, from the medical record, of any information that may be required by third party payors when such information is necessary to reimburse healthcare providers or is necessary to make payment pursuant to a policy of insurance.

___CERTIFICATION-AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary or carriers any information needed for this or a related Medicare claim. I request that the payment or authorized benefits be made on my behalf. I assign the benefits payable for this service to the organization furnishing the services or authorize such organization to submit a claim to Medicare for payment for me.

___ ASSIGNMENT OF BENEFITS

I hereby authorize payment directly to PT Unlimited, Inc. for any applicable third-party payment for therapy services, not to exceed the provider's regular charges for this period of service. I understand that I am financially responsible for charges not covered by this assignment. I agree that any payment made by any third-party payor shall not prevent it from taking action in connection with the validity of my policy nor shall such payment in any event waive any of the terms, conditions or limitations thereof. If assignment of the third-party payor benefits is not acceptable, please make a check payable to the provider and forward to PT Unlimited, Inc., 1638 Tiffany Ridge Drive, Pittsburgh, PA 15241.

__ACKNOWLEDGE OF RECEIPT

My signature acknowledges my receipt of this Medicare message from PT Unlimited, Inc. on _____ and does not waive any of my rights to request a review or make me liable for any payment, except as provided by law.

_____ _____
Signature of patient/guarantor Date

_____ _____
Signature of responsible party Date