Forte' Patient Information Sheet

Patient Information

Name: _____ DOB: _____

Marital Status: S M D W Sex: M F Social Security: _____

Address: _____

Email: _____ Employer: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Emergency Contact: _____ Emergency # _____ Relationship _____

Insurance Information

Primary Insurance: _____

Policy # _____ Policy Holder _____ Policy Holder DOB _____

Secondary Insurance: _____

Policy # _____ Policy Holder _____ Policy Holder DOB _____

Medical Information

Referring Doctor _____

Are you enrolled in home health/ or had homehealth in the last month? _____

Have you had physical therapy in the past month? _____

What problem brings you to therapy? _____

Have you had therapy for THIS condition before, if so, where? _____

Known allergies: _____

Prior surgeries/hospitalization (last 10 years): _____

Current list of medications and dosage: _____

Current pain level 1 2 3 4 5 6 7 8 9 10

Worst pain level 1 2 3 4 5 6 7 8 9 10

Best pain level 1 2 3 4 5 6 7 8 9 10

What are YOUR goals for therapy treatment?

_____

_____

Medical History

**Please check all that apply*

Condition	Yes	Comments	Condition	Yes	Comments
Respiratory(COPD)			Diabetes Mellitus		
Asthma			Cancer		
High Blood Pressure			Kidney/Urinary		
Low Blood Pressure			Epilepsy/Seizures		
Dizziness			Gastrointestinal		
Heart Disease			Heart Attack		
Circulation/Vascular			Stroke		
Arthritis			Skin Problems		
Osteoporosis			Pacemaker		
Psychiatric History			Joint Replacement		
Other			Pregnancy		

_____ _____

Signature ***Date***

Forte' Estimated Insurance Benefits/Privacy Notice

Estimated Insurance Benefits

Forte Rehabilitation & Wellness Center is an *in / out* network provider for _____.
As of _____/_____/_____, your insurance carrier estimates that you are responsible for $_____ of your annual deductible. Once your deductible is met, you are responsible for $_____ copay/coinsurance per visit and agree to pay these charges at the time of service.

Any supplies issued in support of your therapy are to be paid in full on the date you receive them. Forte' Rehabilitation & Wellness Center will bill your insurance if requested.

I understand my estimated insurance benefits and personal payment responsibilities. I also understand it is an estimate and my benefits are verified as a courtesy. I may be responsible for a balance once insurance claims have processed.

Intials

Notice of Privacy

As part of your healthcare, this clinic originates and maintains health records describing your health history, symptoms, test results, diagnosis, treatment, and any plans for future care or treatment.

This information serves as:

- A basis for planning your care and treatment
- A means of communication among the many healthcare professionals who contribute to your care
- A source of information for applying your diagnosis and treatment information to your bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures.

Intials

Assignment of Benefits

I do hereby agree to give my consent for Forte' Rehabilitation and Wellness Center to furnish medical care and treatment considered necessary and proper for my physical condition. I assign all medical benefits to which I am entitled; including Medicare, private insurance or any other health plan, to Forte' Rehabilitation and Wellness Center. I hereby authorize Forte' Rehabilitation and Wellness Center to release all information necessary, including medical records, to secure payment.

_____ _____

Signature ***Date***