



Patient Information

Name: _____ DOB: _____
Address: _____ SSN(for billing): _____
Phone: _____ Email: _____
Employer/Occupation: _____
Name of Spouse/Guardian: _____ Physician: _____
Emergency Contact: _____ Ph: _____

Primary Insurance

Insurance Company: _____ Insured Employer: _____
Name of Insured: _____ Insured ID Number: _____
Group Number: _____

Secondary Insurance

Insurance Company: _____ Insured Employer: _____
Name of Insured: _____ Insured ID Number: _____
Group Number: _____

Reason for today's visit: _____
☐ New Injury: _____ ☐ Surgery: _____
☐ Old Injury: _____ Date: _____
☐ Chronic Pain: _____ Follow Up: _____
☐ Imaging Completed? **X-Ray / MRI / CT SCAN** ☐ Worker's Comp - Injury Date: _____

Has your complaint **improved / worsened / stayed the same** with time?

Goals/expectations of treatment: _____

Current medications: _____

Daily activities affected: _____

Check any of the following that apply to you:

- | | | |
|---|--|--|
| ☐ Alzheimer's Disease | ☐ Fracture/Suspected Fracture | ☐ Fainting or Dizziness |
| ☐ Cancer: _____ | ☐ Osteo/Rheumatoid Arthritis | ☐ Pregnant/Possibly |
| ☐ Diabetes Type I / II | ☐ Heart Disease/Chest Pain | ☐ Headaches |
| ☐ High Blood Pressure | ☐ Breathing Problems | ☐ Stroke/Head Injury |
| ☐ Previous surgeries: List below | ☐ Circulation Problems | ☐ Fibromyalgia |

Are you in pain today? Yes / No

Rate your pain on the following scale: (circle one)

Today: None 0 1 2 3 4 5 6 7 8 9 10 worst possible

At worst: None 0 1 2 3 4 5 6 7 8 9 10 worst possible

At best: None 0 1 2 3 4 5 6 7 8 9 10 worst possible

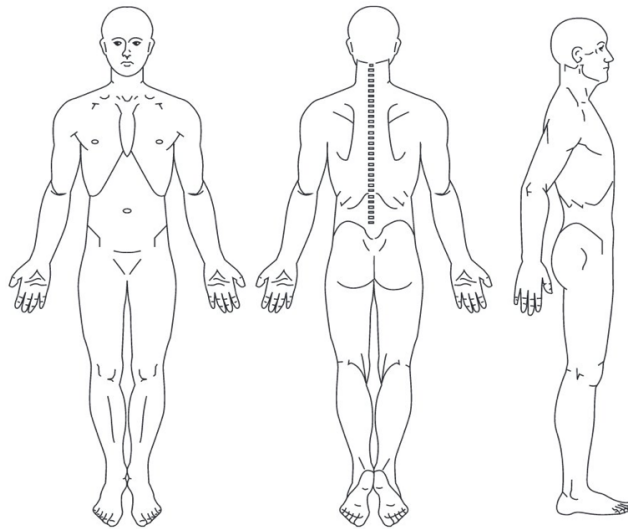
Please mark the following pain diagram:

X for sharp pain

O for dull ache

/// for burning pain

*** for numbness or tingling



I hereby authorize payment of medical benefits billed to my insurance to FPT. I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance if the Practice does not participate with my insurance. I agree to pay all copayments, coinsurance, and deductibles at the time the service is rendered. *I understand if I have an unpaid balance to FPT and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. I will be responsible for reimbursement of the fee of any collection agency, which may be based on a percentage at a maximum of 35% of the debt, and all costs and expenses, including reasonable collection and attorney's fees incurred during collection efforts.*

In order for FPT or their designated external collection agency to service my account, and where not prohibited by applicable law, I agree that FPT and the designated external collection agency are authorized to (i) contact me by telephone at the telephone number(s) I am providing, including wireless telephone numbers, which could result in charges to me, (ii) contact me by sending text messages (message and data rates may apply) or emails, using any email address I provide and (iii) methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable. Furthermore, I consent to the designated external collection agency to share personal contact and account related information with third party vendors to communicate account related information via telephone, text, e-mail, and mail by notification.

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient may revoke this Consent in writing at any time and full disclosures will cease.
- The Practice may condition treatment upon the execution of this Consent.

Signature of Patient or Legal Representative

Date

