12261 Hwy 49, Suite 1
Gulfport, MS 39503-2976
Phone: 228-265-7185
Fax: 833-219-5405

New Patient Information

Patient Name:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone: (_____)_____-_____ Work: (_____)_____-_____ Cell: (_____)_____-_____

SSN:_____ Patient Email:_____

Date of Birth:_____ Age:_____ Gender: Male Female

Appointment Reminder Preference (Please circle one): Phone Text None

Marital Status: Married Single Divorced Widowed

Emergency Contact Name:_____ Relationship:_____

Emergency Contact Phone #:_____

Primary Physician:_____ Who referred you to us?_____

Employer:_____

Status: Full-Time Part-Time Retired Unemployed

Primary Insurance:_____ Policy Number:_____

Secondary Insurance:_____ Policy Number:_____

Are you a student: No Full-Time Part-Time

EMPLOYMENT INJURY or AUTOMOBILE ACCIDENT ONLY

Body Part Injured:_____ Date of Accident:_____

State Accident Occurred:_____

Circle One: Employment Related Auto Accident Other:_____

Adjuster Name:_____ Contact Number:_____

NAME:_____ DATE:_____

ARE YOU CURRENTLY RECEIVING HOME HEALTH? YES NO (PLEASE CIRCLE ONE)

Are you here today because you recently had surgery:_____

What was the date of your surgery:_____

Do you have a pace maker or any other internal pumps? ____ Y ___ N If Yes Where? _____

Are you currently using an assisted device? ___Y ___N If Yes Which Ones?_____

What is your main complaint today? _____

What are you goals for physical therapy:

_____

Past Surgical History:

_____

_____

Please list all medications you are currently taking (or we can make a copy if you have a list):

_____

_____

Do you have a history of:

__ High Blood Pressure __ Osteoarthritis __Ulcers/GERD/Acid Reflux

__ Heart Condition __ Rheumatoid Arthritis __Cancer __Neurological dz (MS, Parkinsons)

__ Strokes __ Fibromyalgia __Diabetes __HIV or AIDS

__ Osteoporosis __ Seizures __Lupus __Kidney/Liver Disease

Regular Exercise/activity level ____ 0-days/week ____1-2 days/week ____3-5 days/week ____6-7 days/week

Types of activities? _____

In the past 3 months/currently do you have or have you experienced:

__Change in your general health __Fever/chills/sweats __Unexplained weight change (>10lbs)

__Numbness or tingling __Bowel/bladder incontinence __Difficulty sleeping due to pain

__Unexplained falls (or past year)/decreased balance __Pregnant/potentially pregnant/nursing

Do you have any allergies that we need to be aware of? If you do list them.

_____

PLEASE RATE YOUR PAIN/DISCOMFORT ON A SCALE OF **0-10**

Currently: _____ At Best: _____ At worst: _____

(0=NO PAIN, 10=THE WORST PAIN YOU HAVE EVER FELT)

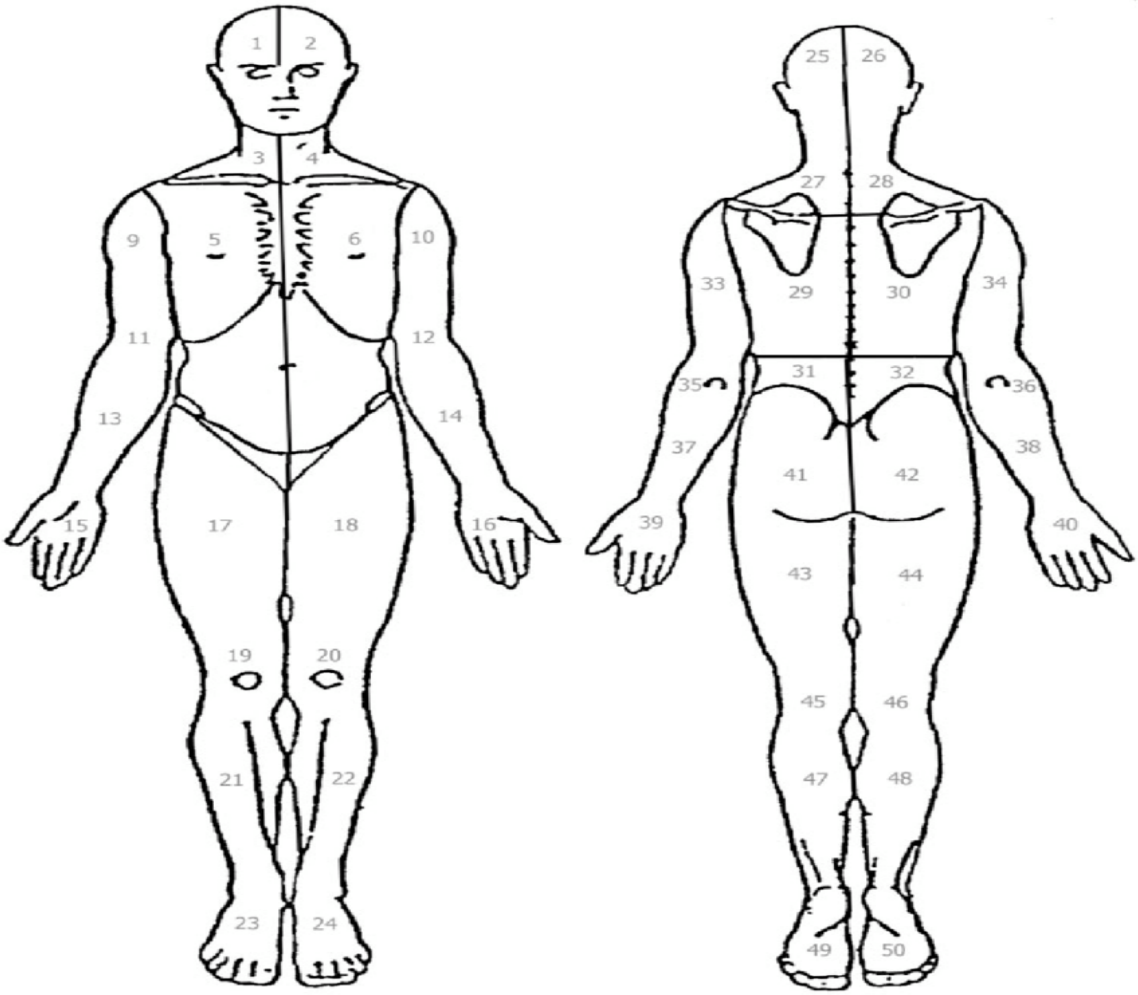
WHERE IS IT LOCATED AND WHAT MAKES IT BETTER AND WORSE?

Pain Location: _____

Pain Better: _____

Pain Worse: _____

Mark or shade in below where your pain is located:



Authorization for Medical Treatment

I, the undersigned, a patient of this office hereby authorize the therapists of Exceed Physical Therapy (and whomever he may designate as his assistants) to administer such treatment, as in necessary and to perform the following examination, manipulation and such additional therapy or procedures as are considered therapeutically necessary on the basis of the finding during the course of said treatment.

Signature:_____ Date:_____

Authorized Provider Representative: _____ Date:_____

Authorization for Payment/Grant of Lien

The undersigned hereby grants a lien to Exceed Physical Therapy (hereinafter referred to as the "CLINIC"). This is a grant of lien against any settlement, claim judgment, decision, or verdict that is in any way associated with the accident, illness or injury for which the undersigned is treated for by this clinic. The undersigned hereby authorizes and directs their attorney and/or insurance carrier to pay directly to the clinic such sums as may be necessary to fully satisfy all sums owing to the clinic. Such payment shall include professional services previously rendered as well as those rendered up to the time of disbursement of any sums realized in connection with the claims such as depositions, court appearances, or providing records, etc… The undersigned understands that he/she is directly and fully responsible for the clinic's bills for services rendered to the undersigned and/or the undersigned further acknowledges that said payment is not contingent upon any settlement, judgment or verdict, and it is acknowledged that the bills from the clinic will be satisfied by the undersigned even if there is no recovery from the claim or claims, The undersigned also agrees to waive any statute of limitations for collection of their bills for professional services incurred in this clinic after any litigation has concluded on this case.

Date:_____

Patient (or Parent/Guardian of Patient) Signature:_____

Authorized Provider Representative: _____ _____

HIPAA COMPLIANCE

Appointment Reminders and Health Care Information Authorization

Your doctor and member of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminder, information and treatment alternatives, or other health-related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information both by phone and by mail.

We are allowed to use your information for the purposes of healthcare treatments, obtaining payment and general healthcare operations, this includes but not limited to Worker's Compensation, collection agencies, managed care networks, and electronic clearinghouses. You may restrict individuals outside the aforementioned entries to which your healthcare information is released, or you may revoke your authorization to us at any time. You also have the right to request an amendment to our privacy practices that are within the compliance of the HIPAA guidelines. In both instances, requests must be in writing and mailed to our office at 12261 Hwy 49 Suite 1, Gulfport, MS 39503. Amendments may be denied if deemed compliant with HIPAA guidelines and a written denial will be sent to your home address that is currently on file unless otherwise noted. Please note we will not be able to honor your revocation if we have already released your health information before we receive your request to revoke your authorization. Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse us this authorization. If you do give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care. You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time. (Section 164.524)

The notice is effective as of the **_____day of_____, 2023**. This authorization will expire in six years after your last date of service from our office. I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

_____ _____

Patient Printed Name **Date**

_____ _____

Patient Signature **Authorized Provider Representative**