Alliance Therapy Services

Admit/Medical History Form

Patient Name:________________________________ DOB:____________ E-Mail Address:_______________________

Home Address:____ City:__________________ State:____ Zip:_________

Home Phone:________________ Work:________________ Cell:________________ Sex:_____ Marital Status:_______

DL#:__________________ SS#:__________________ Date of Injury:_____________ Area of Pain:_________________

Insured's Name:____ Insured's Date of Birth:_____________

Referring Physician:________________ Primary Care Physician:________________ Next Physician Visit:____________

Place of Employment:____ Job Title:_____________________________

Explain how injury occurred:____

Any medical conditions that warrant Special Attention?:____

Have you attended outpatient physical/occupational/speech therapy this year? ________ yes ________ no

Are you currently receiving home health services? _________ yes _________ no

In case of emergency, notify:____________________________ Relationship:_______________ Phone:______________

Do you have an attorney representing you for this injury? _________ yes _________ no

Where did you hear about us? _____ Physician _____ Friend _____ Family Member _____ Social Media _____ Other

I understand that any and all charges for this treatment will be my personal responsibility. I also certify that the above information is correct.

I understand that I will be charged 1.5% interest (monthly) on all balances (deductibles, co-pays, co-insurance, and non-covered charges) that are not paid by my insurance carrier/attorney/or third party carrier, and that is owed by me by 30 days after discharge. If for any reason an amount is turned over to a collection agency, there will be a fee of $25.00 in addition to the balance on the account.

Date:__________ Signature:____________________________________

Past Medical History

Please indicate whether you have had any of the following conditions:

Condition			Condition		
Heart disease or heart attack…………..	□ Yes	□ No	Stroke………………………………..	□ Yes	□ No
Epilepsy or convulsions……………….	□ Yes	□ No	Diabetes…………………………….	□ Yes	□ No
Tumor or cancer……………………….	□ Yes	□ No	Respiratory disease………………….	□ Yes	□ No
Tuberculosis…………………………...	□ Yes	□ No	Asthma………………………………	□ Yes	□ No
Hepatitis……………………………….	□ Yes	□ No	Hernia……………………………….	□ Yes	□ No
Venereal disease……………………….	□ Yes	□ No	Are you now pregnant?.....................	□ Yes	□ No
Congenital abnormalities……………...	□ Yes	□ No	Do you have a pacemaker?................	□ Yes	□ No
Anemia or other blood disorder………	□ Yes	□ No	Do you have any surgical implants?...	□ Yes	□ No
Bleeding disorders…………………….	□ Yes	□ No			

Family History

Has any blood relative ever had any of the following:

Cancer………………………………	□ Yes	□ No	Stroke…………………………….	□ Yes	□ No
Arthritis…………………………….	□ Yes	□ No	Gout………………………………	□ Yes	□ No
Diabetes……………………………..	□ Yes	□ No		□ Yes	□ No

Medications

Please list ALL present medications:

Surgery

Please list ALL previous operations, fractures and other serious injuries:

Date	Surgery	Age

Conditions and Admission to Alliance Therapy Services, Inc:

Release of Information. The agency may disclose all or any part of the patient's record to any person or corporation which is or may be liable under a contract to the agency or to the patient or to a family member or employer of the patient for all or part of the agency's charge, including but not limited to, hospital or medical service companies, insurance companies, workmen's compensation carriers, welfare funds, or patient's employer.

Treatment Consent. The patient is under the control of his/her physician, and the undersigned consents to any treatment or procedures rendered the patient by the agency under the general and specific instructions of the physician. It is further understood that the agency is authorized to carry out all instructions of the patient's doctor and that the agency is hereby relieved of any and all liability occurring from the performance of the doctor's instructions.

I request and authorize staff of Alliance Therapy Services, Inc. to provide me with treatment, and to perform any procedures now contemplated or such additional procedures as my doctor may deem reasonable and necessary.

I authorize Social Security Administration to disclose information regarding my Medicare coverage, including but not limited to, verification of my Medicare number, effective dates, and type of coverage.

Assignment of Benefits. I hereby authorize my insurance company to pay directly to Alliance Therapy Services, Inc. all benefits due me, if any, by reason of services described in the statements rendered, and as provided for in the above policy contract with insurance company. I understand that Alliance Therapy Services, Inc., which has accepted assignment, has the same right as I do to appeal carrier's determination.

The undersigned certifies that he/she has read the foregoing and is the patient, or is duly authorized by the patient as patient's general agent to execute the above and accept its terms. It is further understood that this release remains in effect for one (1) year unless otherwise revoked.

Financial Responsibility. I hereby accept all responsibility for treatment costs not covered or reimbursed by third-party payers. The undersigned certifies that he/she has been explained the treatment costs and is the responsible party and accepts these terms.

Patient Signature: ______________________________ Date: ________________

Signature of Person Authorized to Sign in Lieu of Patient:

______________________________ ________________

Relationship to Patient Reason why Patient us unable to sign