



Patient Information

First Name _____ M.I. _____ Last Name _____
Street Address _____
City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Work Phone _____
Email Address _____ Married Single Divorced Widowed Other
Date of Birth _____ SS# (if minor, leave blank) _____
Student? F/T P/T NO What school do you attend? _____ Grade _____
Physician Name _____ Date of Last Appt ____/____/____ Phone# _____
Emergency Contact Name / Relation to Patient _____ / _____ Phone# _____
Injury / Ailment _____ Date of Onset _____

Patient / Parent / Guardian Information

Please Check Applicable: Patient (if patient, skip down to Employer Info) Mom Dad Other
First Name _____ M.I. _____ Last Name _____
Street Address _____
City / State / Zip _____
Home Phone _____ Cell Phone _____ Work Phone _____
Date of Birth _____ SS# _____

Employer Information

Name of Employer _____ Occupation _____
Employer Street Address _____ City / State / Zip _____
Employment status: Full time Part time Retired Date Retired: _____ Other _____

Insured Person's Information

Will we be billing insurance? YES (please provide Insurance Card) NO
NAME OF INSURANCE _____
Name of Person Insured _____ Relation to patient: Spouse Parent Other _____
Address of Insured (if different than above) _____ City / State / Zip _____
Name of Insured's Employer _____ Insured's SS# _____
Employer Street Address _____ City / State / Zip _____

MEDICAL HISTORY

Please take a moment to complete the questions below. Depending on your answers, we may modify our treatment procedures for their effectiveness and your safety. Thank you!

Do you have or have you had any of the following:

Cancer	<input type="radio"/> Yes	<input type="radio"/> No	
Diabetes	<input type="radio"/> Yes	<input type="radio"/> No	
Epilepsy	<input type="radio"/> Yes	<input type="radio"/> No	
Heart Disease	<input type="radio"/> Yes	<input type="radio"/> No	
High Blood Pressure	<input type="radio"/> Yes	<input type="radio"/> No	
Metal Implants	<input type="radio"/> Yes	<input type="radio"/> No	
Respiratory Problems	<input type="radio"/> Yes	<input type="radio"/> No	
Are you Pregnant?	<input type="radio"/> Yes	<input type="radio"/> No	
Psychological Problems	<input type="radio"/> Yes	<input type="radio"/> No	
Allergies	<input type="radio"/> Yes	<input type="radio"/> No	If Yes, What _____

Are there any other medical conditions we should be aware of? _____

Current Medications _____

Surgeries (What/Where/When) _____

Recent Illnesses (What/When) _____

WORK RELATED INJURY

Were you injured at work? Yes No

Date of Injury Mo ___ Day ___ Yr ___

Name of Compensation Carrier _____

Street Address _____

City/State/Zip _____

Claim Number _____

AUTO RELATED INJURY

Were you injured in a traffic accident? Yes No

Date of Accident Mo ___ Day ___ Yr ___

Name of Automobile Insurance Carrier _____

Street Address _____

City/State/Zip _____

Policy # _____ Claim # _____

Insurance Co Phone# _____

DATE OF ONSET: _____

1. Briefly Describe your symptoms:

2. How did your symptoms start?

3. Average pain intensity

LAST 24 HOURS	no pain	0	1	2	3	4	5	6	7	8	9	10 worst pain
PAST WEEK	no pain	0	1	2	3	4	5	6	7	8	9	10 worst pain

4. How often do you experience your symptoms?

- Constantly (76%-100% of the time)
 Frequently (51%-75% of the time)
 Occasionally (26%-50% of the time)
 Intermittently (0%-25% of the time)

5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework)

- Not at all
 A little bit
 Moderately
 Quite a bit
 Extremely

6. In general, would you say your overall health right now is...

- Excellent
 Very good
 Good
 Fair
 Poor

Pain Diagram

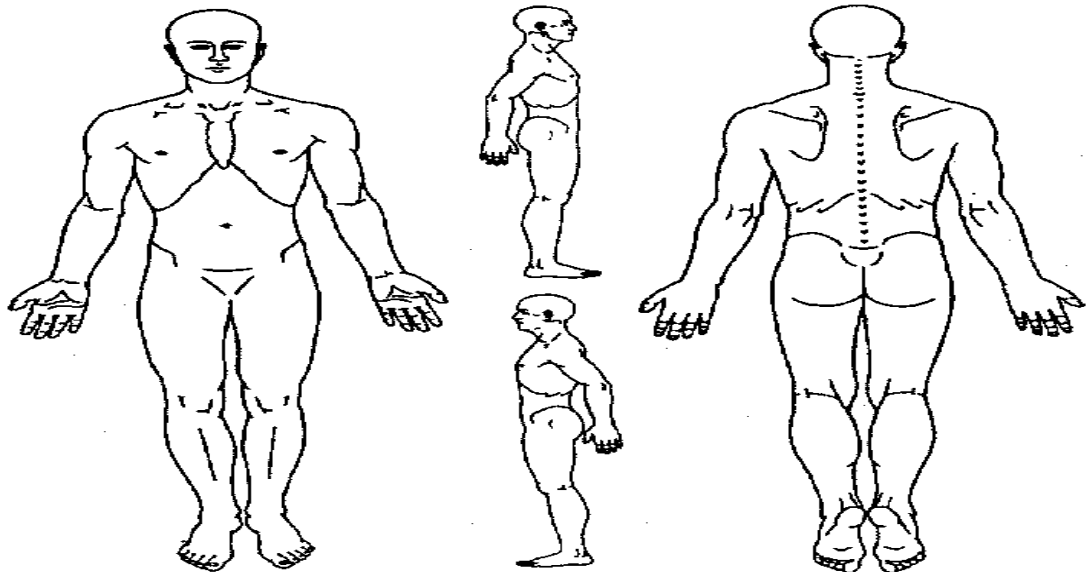
Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:

Numbness

Pins & Needles
 O O O O O

Burning
 ^ ^ ^ ^ ^

Aching Stabbing
 X X X X □ □ □ □ □ □ □ □



Next Level Physical Therapy, P.C.
221 Corporate Circle, Suite J
Golden, CO 80401
Phone (303) 279-6000 Fax (303) 279-7799

FINANCIAL POLICY STATEMENT

For and in consideration of services rendered by Next Level Physical Therapy, P.C. (Next Level) I agree to pay all fees in accordance with rates agreed to by me at the time of the service or based on the rates set forth in my Insurance Company's Explanation of Benefits (EOB). I further understand that I am responsible for those authorized fees not covered by my insurance company and for any co-payment that is established by my insurance company. Co-payments are due at the time of service.

If any payment is made directly to me by my insurance company for services billed by Next Level I recognize an obligation to promptly remit same to Next Level.

Cancellation Policy: Unless I cancel a set appointment at least 24 hours in advance, I will be charged for the missed appointment at the rate of a normal visit. This fee is outside of reimbursable insurance coverage and is my sole responsibility.

The above does not apply for those patients that are considered Worker's Compensation cases. However, be advised if W/C benefits are subsequently denied that I will be held responsible for the total amount of charges for services rendered to me. The prescription from the Doctor authorizing physical therapy must clearly indicate that workman compensation is involved.

I agree to pay all charges within 30 days of billing. Billing will occur at the earlier date of when the EOB is processed by Next Level 60 days after billing to the insurance company should the insurance company fail to reply. I agree to pay Next Level interest at the rate of one and one-half percent (1.5%) per month eighteen percent per annum (18%) for any amounts not paid with in 30 days of billing as defined herein.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, that I am responsible for interest as stipulated above as well as for all collection costs including but not limited to court costs, collection agency fees, and attorney fees.

Agreed to this _____ day of _____, 200_____.

Patient Name Printed

Patient or Legal Guardian Signature

