OMTA Physical Therapy
1827 Wehrli Road
Naperville, IL 60565
Phone: 630-637-1693 Fax: 630-470-9256

Last Name:	First Name:	Middle Initial:
How do you prefer to be addressed?	DOB: _____/_____/_____	Age:
Marital Status: ❑ S ❑ D ❑ M ❑ W	Sex: ❑ F ❑ M	
Address:	City, State, Zip:	
Home Phone:	Cell/ Work Phone:	
Occupation:	In case of Emergency, contact: Phone:	
How would you like to be contacted for appointment reminders? ❑email ❑text ❑phone Contact cell number/ email ID:		

Guarantor or Parent Information

Name of the Insurance Holder:	
Employer Name (for the insurance holder):	
Employer Phone:	**Date of Birth (of the insurance holder):**

What complaint(s) brings you to physical therapy?

Onset date:

Complaints/ symptoms:

Are your symptoms getting: ❑ better ❑ worse ❑ staying the same

Any other treatment(s) you have received for this condition (circle the ones which are appropriate):

❑ Physical Therapy ❑ Chiropractic ❑ Surgery ❑ Medicine ❑ Spine Injection ❑ Joint Injection

Mark test(s) you have received for this condition. ❑X-ray ❑ MRI/CT ❑EMG ❑ Ultrasound
❑other_____

Rate the INTENSITY of your pain:

0 1 2 3 4 5 6 7 8 9 10

← No pain Worst pain imaginable →

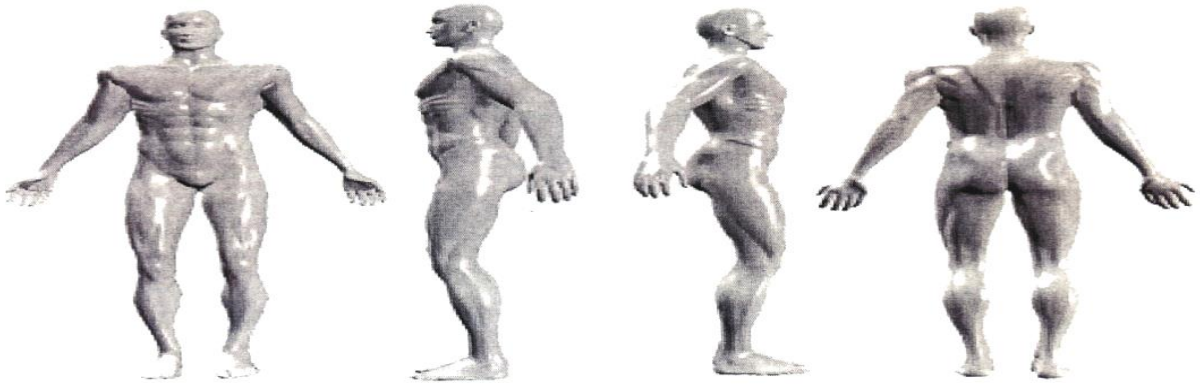
OMTA Physical Therapy
1827 Wehrli Road
Naperville, IL 60565
Phone: 630-637-1693 Fax: 630-470-9256

Do you have any of the following medical conditions? :					
Condition	**Yes**	**No**	**Condition**	**Yes**	**No**
Diabetes			Pregnancy (recent or current)		
Arthritis			Fracture		
Bowel or bladder accident			Pace Maker		
Cancer			High Blood pressure		
Depression			Any Surgery		
On Blood thinners			Other/ Hepatitis / HIV:		

What activities increase your pain?
What helps decrease your pain?
What are you unable to do because of your symptoms?

Circle where you are experiencing symptoms

Describe your symptoms: ❑Sharp Pain ❑Dull Ache ❑Numbness and Tingling
❑Radiating Pain ❑Stiffness ❑Other _____



OMTA Physical Therapy
1827 Wehrli Road
Naperville, IL 60565
Phone: 630-637-1693 Fax: 630-470-9256

Insurance and Payment

Please be advised that it is your responsibility to check the benefits of your insurance policy for physical therapy services, including deductibles, and co-pays/co-insurance amounts for your visits. All deductibles/ co-pays must be paid at the time of service.

NOTE: There will be a $5/ surcharge for each statement mailed to you after the first statement. Regarding collections, in case we proceed for bills unpaid for 2 months: You agree to reimburse us for all fees and costs assessed by any collection agency.

Agreed:

_____ _____
Patient or Authorized Person's Signature Date

CREDIT CARD AUTHORIZATION (to pay your balance and avoid late/collection fees mentioned above). We will charge your card after mailing you 2 statements.

Card Type (Pls. circle one): **Master** **Visa** **Discover**

Card Holder's Name:_____ Security Code: _____

Credit Card Number: _____ Exp Date: _____

I hereby authorize OMTA to charge my above referenced credit card for all bills which remain unpaid for 60 days. I understand that these charges will reflect on my credit card statement as "Orthopaedic Manual Therapy."

Agreed:

_____ _____
Patient or Authorized Person's Signature Date

Witness:_____

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed OMTA's Notice of Privacy Practices which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____
Patient or Authorized Person's Signature Date

OMTA Physical Therapy
1827 Wehrli Road
Naperville, IL 60565
Phone: 630-637-1693 Fax: 630-470-9256

"No Show" and "Cancellation" Policy & Procedure

At OMTA Physical Therapy, our goal is to provide quality physical therapy services in a timely manner. We have implemented a "No-show" and "Cancellation" Policy which enables us to better utilize available appointments for our patients in need of physical therapy. The following policy is with regard to patients who fail to keep their scheduled office visit appointment.

- Patients who fail to appear for their scheduled appointment or did not notify the office **24 hours prior to their scheduled appointment time**, shall be subject to a **"No Show/Cancellation" fee of $35.00**. In the event of an actual emergency and prior notice could not be given, consideration will be given to a one-time exception.
- This fee is not covered by insurance and is therefore the sole responsibility of the patient.

How to Cancel Your Appointment:

To cancel or reschedule 24 hours prior to your scheduled appointment please call OMTA Physical Therapy at **630-637-1693**. If you have any problem getting through, leave a message with your name, appointment date and time, cancellation reason or request for rescheduling.

Please be courteous and call OMTA Physical Therapy promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of physical therapy treatment. Available appointments are in high demand and your early cancellation will give another person the opportunity to have access to timely care.

Agreed:

Patient Signature: _____

Patient Printed Name: _____

Date: _____