Patient Pre-Exam Form

Atlas Physical Therapy

_____Consent to Treat (*Please Initial- see policy on Page 3)*

Patient Name: _____Date: _____

Where is your pain/problem? _____

What caused your problem? _____

Date when problem started or worsened _____(mm)/_____(dd)/_____(yy)

Pain Description (circle all that apply):

Sharp	Achy	Numb/Tingling	Constant	Intermittent	n/a

WORST your pain has been in the past week? (0=no pain, 10=worst pain)

0	1	2	3	4	5	6	7	8	9	10

Your CURRENT pain level ? (0=no pain, 10=worst pain)

0	1	2	3	4	5	6	7	8	9	10

BEST your pain has been in the past week? (0=no pain, 10=worst pain)

0	1	2	3	4	5	6	7	8	9	10

Medical History:

- ○ None
- ○ High Blood Pressure
- ○ Pacemaker
- ○ Chronic Pain
- ○ Stroke
- ○ Current Smoker
- ○ Diabetes
- ○ Cancer
- ○ Mental Health
- ○ Fractures
- ○ Fibromyalgia
- ○ Osteoporosis
- ○ Osteopenia
- ○ Other:

_____

_____

Past Surgeries & Dates: _____

_____

Current Medications: (list each or provide staff with written list): _____

_____

Have you had any falls in the past year? (circle one) YES NO

Height: _____ Weight: _____

P: 410.762.2124
F: 410.705.5057

atlas@iwantpt.com
www.iwantpt.com

1406 Crain Hwy S
Suite 110
Glen Burnie, MD 21061

Patient Registration

Atlas Physical Therapy

Date: _____

Name (First, Middle, Last): _____

Nickname: _____

Primary Phone: _____ Cell Home Work (circle one)

Social Security Number: _____

Primary Address: _____

Email: _____

Insurance: _____ Secondary: _____

Policy Holder (if other than self): _____

DOB of Policy Holder: _____ Relationship: _____

Referring Doctor: _____

Primary Care Doctor: _____

How did you hear about us?: _____

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Policies - Please initial each.

Atlas
Physical Therapy

_____Attendance Policy:

I am responsible for attending physical therapy sessions as scheduled. I understand if I am late or fail to give appropriate cancellation notice, I will hinder my potential outcome. I understand that my physical therapist has designated appointment times to assist me in my recovery. I will provide **at least 24 hours' notice** to cancel a scheduled appointment. Failure to comply with this policy may result in a $65.00 charge. I understand that this charge will be billed DIRECTLY to me, the patient, and is NOT covered by insurance.

_____Consent to treat

I hereby agree and give my consent for Atlas Physical Therapy to provide physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition. This consent is intended as a waiver of liability for such treatment, excluding acts of negligence.

_____HIPAA:

I am aware of Atlas Physical Therapy's HIPAA policy and how my personal and medical information will be used. I am aware that I can request the document in its entirety from any staff member, at any time.

_____Financial Responsibility:

I agree that I am ultimately responsible for any charges incurred at Atlas Physical Therapy for services rendered.
I hereby agree to the policies that I have acknowledged with my initials above.

_____ _____
Patient Signature Date

No-Show / Same-day Cancellation Policy

At Atlas PT, we expect you to get the most out of your physical therapy visits. Your physical therapist will provide you with your plan for care during the evaluation appointment and will inform you of the required number of visits to help you meet your goals. A recent study has shown that patients who adhere to their physical therapy plan of care increase their ability to have success from physical therapy by 93%.

Even one missed visit can significantly decrease your success and result in a more chronic problem. We strongly stress the importance of keeping all scheduled appointments to achieve your personal physical therapy goals.

Our schedule is very full and certain time slots are not always available for patients who need them. For this reason, we expect at least 1 days' notice if you cannot attend an appointment; for any reason. If you cannot make a scheduled appointment, for any reason, we require a day's notice of the cancellation. When you call we will assist you in rescheduling this appointment because getting you results is our main goal.

Please read the following policy and sign at the bottom indicating you understand our same-day cancellation / no-show policy and agree to adhere to the expectations listed below.

1. As experts, we know that you will not get better if you do not attend your appointment. When you call to cancel an appointment, we expect that you will have other times available so we can reschedule you right away.
2. We require that you cancel any appointment that you cannot make with no less than 24 hours' notice.
3. We will reschedule you at that time to make sure you continue with your plan of care.
4. While we understand that illness can strike at anytime, repeated cancellations for illness without 24 hours' notice will not be an accepted excuse for untimely notice.
5. For all appointments, we expect that you will arrive on time, dressed for your session, and ready to begin at your scheduled treatment time.
6. While traffic can be unpredictable, we expect that you will call us immediately if you are running late for your scheduled appointment, so we can be prepared for your late arrival.
7. Please also be aware that if you are late for your appointment, you are missing the time that we have specifically scheduled for your care and we cannot guarantee that we will be able to provide you with your full treatment as we have reserved the appointment time following yours for someone else. Chronically late patients will be asked to change their appointment times.
8. **Please note, you will be charged a $65 fee for any no-shows and ALL cancellations that occur with less than 24 hours' notice. This amount is your responsibility as insurance will not cover this fee.** To avoid the $65 fee, you simply need to call the office and provide at least 24 hours' notice for any appointments you cannot attend. Calls the night before your appointment will not count as timely notice so please call during business hours.

Thank you for reviewing this policy. Please sign and return the signed copy and keep the second copy for your records.

We look forward to working with you to meet your physical therapy goals.

Dr. Laura Sanner, Owner

I have read this policy and by signing below I am indicating that I understand and will adhere to this policy.

Patient Signature	Patient Name	Date