Ultimate Treatment Zone
Physical Therapy LLC

MEDICAL QUESTIONNAIRE

Patient Name:_____ **DOB:**_____ **Today's Date:**_____

Past Medical History (Please list or provide copy of all medical history): _____

_____

Have you had a recent illness? If yes, exlplain:_____

Any other previous injuries? Please list:_____

_____

Surgeries / Hospitalizations? Please list:_____

_____

Any pertinent family medical history?_____

Current Medical History: Please list any other current medical condition / illness not listed:_____

*During the past 3-6 months, have you had or have you experienced:

A change in your health _____	Numbness or tingling _____	Shortness of Breath ___
Nausea/Vomiting _____	Changes in appetite _____	Dizziness (Vertigo) _____
Fever/Chills/Sweats _____	Difficulty swallowing _____	Upper respiratory infection _____
Unexplained weight loss _____	Changes in bowel or bladder function _____	Urinary tract infection_____

Current Medications and reason for taking (please list or provide copy of all medications):_____

_____

_____

What are your goals for therapy at this time?_____

Aggravating Factors: Identify up to 3 important activities that you are unable to do or are having difficulty with as a result of your problem. List them below:

1) _____ 2)_____ 3)_____

Acknowledgement of Receipt of Notice of Privacy Practice:

I, _____, hereby acknowledge receipt of U.T.Z. P.T.'s Notice of Privacy Practices.

Signed:_____ Date:_____

Informed Consent (Rule R4-24-303.C)

Please review the following information and sign:
My therapist has reviewed with me a plan of care to address my goals for rehabilitation and has explained the treatment approach. We have discussed the benefits and risks of treatment and also discussed alternative interventions as appropriate.

I give consent for treatment: _____ Date: _____

Guardian's Signature of consent: _____ Date: _____

Witness: _____ Date: _____

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PATIENT ORIENTATION & BILLING POLICY

Be aware of the following amenities and policies regarding your care:

- Please arrive on time for your scheduled appointment. The time is reserved for you.
- Please give at least 24 hour notice if you must cancel or reschedule an appointment. **Your physical therapist reserves the right to charge a $75.00 cancellation/no-show fee for each missed appointment.**
- Please wear or bring appropriate clothing in order to maintain modesty, be comfortable and exercise freely.
- Please let us know if your health insurance changes, so we can make sure the benefits and billing information are accurate.
- Billing policy, release and authorization:
  I authorize Ultimate Treatment Zone Physical Therapy, LLC to bill my insurance company directly for the covered portion of charges, and I authorize payment of medical benefits directly to Ultimate Treatment Zone PT. I authorize Ultimate Treatment Zone PT to release medical or other information necessary to process this claim. **I understand that I am ultimately responsible for my physical therapy charges, and I agree to pay my deductible, my co-insurance or co-payment, and any other charges not reimbursed by my insurance carrier.** I understand that some insurance companies require medical or administrative pre-authorization for treatment, or have reimbursement limits on physical therapy treatment. I understand I am responsible for knowing and meeting the requirement of my insurance plan.
- My insurance information (co-pays, deductibles, co-insurance, etc.) has been reviewed with me and I choose to continue with treatment.
- Please indicate preferred method of payment for treatment (deductible, co-pay, co-insurance, non-covered limits, etc.) Cash_____ Check_____ Visa/MasterCard_____

Patient Name:_____ Date of Birth:_____
(Please Print)

Signed:_____ Date:_____
(Patient or Patient Guardian)

Witness: _____ Date: _____

Revised 10/03/2022