F&S
Physical Therapy
1414 Hwy 71 N
Alma, AR 72921
P: 479-632-0321
F: 479-632-0323

Wellness
Physical Therapy
9220 Hwy 71 S, Ste 4
Fort Smith, AR 72916
P: 479-484-1100
F: 479-484-1105

Wellness
Physical Therapy
418 E Main
Charleston, AR 72933
P: 479-965-0357
F: 479-965-0359

Waldron
Physical Therapy
56 W 2nd St
Waldron, AR 72958
P: 479-637-0744
F: 479-637-0755

Wellness
Physical Therapy
732 Hwy 270 East
Mount Ida, AR 71957
P: 870-867-2121
F: 870-867-0113

PATIENT INFORMATION

Please present insurance card when registering.
Payment is expected at the time of service unless prior arrangements are made.

PATIENT INFORMATION

Name_____

Address _____

City _____

State _____ Zip _____

Phone _____

Cell Phone _____

___Receive text reminder

___Receive voice reminder

___No reminder

Date of Birth _____

SS# _____

Height _____ Weight _____

PATIENT'S SPOUSE/GUARDIAN

Spouse/Guardian_____

Relationship _____

Address _____

City _____

State _____ Zip _____

Phone _____

Employer _____

Date of Birth_____

SS# _____

Primary Insurance _____ Subscriber ID #_____

Secondary Insurance _____ Subscriber ID #_____

Have you received any physical therapy this calendar year? YES NO

Is this a Workers' Compensation case? YES NO

Is this a Motor Vehicle Accident case? YES NO

I certify the above information is correct to the best of my knowledge. I also understand that I am financially responsible for all charges subject to coverage. I have been told about and understand the Notice of Privacy Practices.

_____ _____

Signature of Patient Date

F & S PHYSICAL THERAPY
Medical History Form

PATIENT NAME: _____ DATE: _____

HISTORY

Exercise Frequency: _____ Exercise Type: _____

Do you smoke? ☐ Yes ☐ No Have you ever smoked? ☐ Yes ☐ No

If so, how often? _____

Do you have a pacemaker? ☐ Yes ☐ No Are you pregnant? ☐ Yes ☐ No

Do you now or have you ever had the following? Please list details and dates:

☐ Cancer: _____

_____

☐ Heart Problems: _____

_____

☐ Diabetes: _____

☐ Neurological Problems: _____

_____

☐ Surgery: _____

_____

☐ Other: _____

COMPLAINT

What is your major complaint? _____

Start Date:_____ Possible Cause: _____

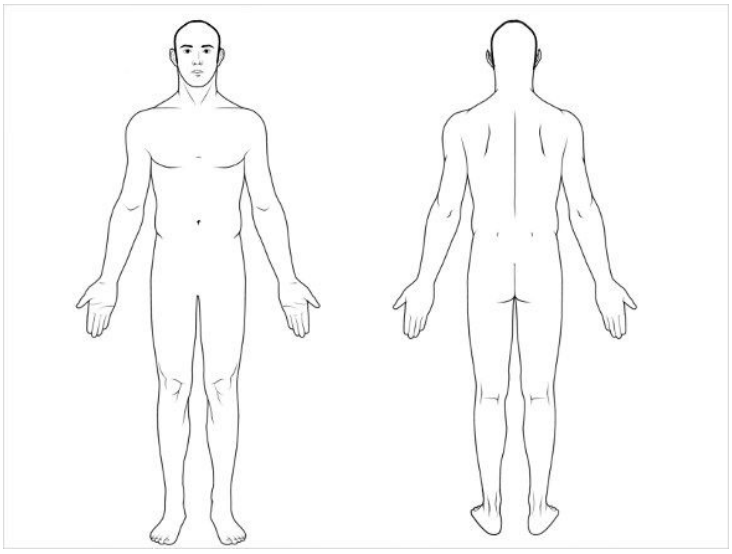
Symptoms:_____

Previous Doctor & treatment: _____ Follow Up Appt:

Current Duration of Pain: Intermittent ☐ Constant ☐ With Certain Motions ☐

Have you had this injury before? ☐ Yes ☐ No

Mark areas of discomfort:



F&S / Wellness Physical Therapy

Patient Acknowledgement Form

_____ I agree and give my consent for F&S / Wellness Physical Therapy, Inc. to furnish me with medical care and treatments that are considered necessary and proper in diagnosing and/or treating my physical condition.

_____ I understand that there is a copy of the Notice of Privacy Practices available for me to read. The HIPAA Privacy Notice describes the Practice's obligation to ensure the privacy of my health information. I know that I have the right to review the Practice HIPAA Privacy Notice and to ask for clarification. I understand that the Practice is required to maintain the privacy of my health information in accordance with the terms of the HIPAA Privacy Notice.

_____ Auxiliary aids and services can be provided without cost upon request. A translator can be provided without cost upon request to communicate with your physical therapist.

_____ By signing this form, I consent to the Practice use and disclosure of my health information for treatment, payment, and healthcare operations. I understand that I have the right to revoke this consent at any time in writing, but if I do, my revocation will not influence any actions the Practice has already taken reliance on this consent.

_____ I understand that I will be subject to a **cancellation fee** of $25 if I do not call and cancel my appointment 24 hours before my scheduled time. I will also be subject to a $25 fee if I do not show up for my appointment (no show).

_____ I hereby assign all physical therapy benefits including Medicare private insurance and third-party payers to F&S / Wellness Physical Therapy, Inc.

_____ I voluntarily refrain from wearing heavy **perfumes or colognes** to my appointment so as not to disrupt treatment for patients that are asthmatic or sensitive to strong scent. Therapy is given in a small area so for this same reason I also agree to **bathe** before my appointment. I understand that if I do not have access to a shower at home I can come to my appointment early and will be able to use the shower at this facility.

_____ If you are a **shoulder patient**, wear a tank top so that the physical therapist can reach your shoulder without having you undress. If you are a **knee patient**, please wear shorts or sweats so that the physical therapist can reach your knee.

_____ _____

Signature of Patient or Patient's Representative Date