Shallyn's Physical Therapy and Wellness Services L.L.C
14950 Wellwood Dr.
Elbert CO 80106
(719) 219-5865 office
(719) 799-6948 fax
shallynsptandwellness@gmail.com
www.shallyns.com

NEW PATIENT INFORMATION AND FINANCIAL AGREEMENT:

Legal Name:_____Date of Birth:_____
Preferred Name:_____
Address:_____
_____
Preferred Phone #:_____
Can we leave a message at this number? Y/N
E-mail: _____

Emergency
Contact:_____
_____
_____
Emergency Phone:_____
Can we talk to your emergency contact about your physical therapy care? Y/N

Referred By/How did you hear about Shallyn's?:_____

Physician Name:_____
Physician's Office Address:_____
Physician's Office Phone #:_____
Physician's Office Fax #:_____

Insurance Company:_____
Name of Insured:_____
Date of Birth of Insured:_____
Social Security Number of Insured: _____

Insurance Company Address for Claims:_____
Insurance Company Phone # for Claims:_____

HEALTH QUESTIONNAIRE:

Please mark any of the following you have had or do have and indicate when:

Abdominal Surgery:_____
Allergies:_____
Anger Issues:_____
Balance Disturbance/Falls:_____
Blood Pressure (High/Low):_____
C-Dif:_____
Cancer:_____
Cold Hands/Feet:_____
Depression:_____
Diabetes:_____
Digestive Problems:_____
Easy Bruising/Bleeding:_____
Elbow Surgery:_____
Foot/Ankle Surgery:_____
Headache:_____
Hearing Impairment:_____
Heart Conditions:_____
Hepatitis:_____
Hernia:_____
Hip Surgery:_____
HIV/AIDS:_____
Kidney Problems:_____
Knee Surgery:_____
Liver Problems:_____
Memory Deficit:_____
Neuropathy:_____
Osteoarthritis:_____
Other Neurological Disease:_____
PTSD:_____
Respiratory Problems:_____
Rheumatoid Arthritis:_____
Shingles:_____
Shoulder Surgery:_____
Sleep Disturbance:_____
Spine Surgery:_____
Stroke:_____
Vision Impairment:_____

Wrist/Hand Surgery:_____

Other:_____
_____

Is this injury auto related? Y/N
Did this injury occur at work? Y/N

Please list regular prescription medications, over the counter medications and supplements you are currently taking or provide a separate printed page with this information:

_____
_____
_____
_____

AUTHORIZATION FOR TREATMENT:
I authorize Shallyn's Physical Therapy and Wellness Services to perform any and all forms of treatment that may be indicated, after they are discussed with me.

PAYMENT AGREEMENT / CANCELLATION POLICY:
I agree that it is my responsibility to understand the terms and limitations of my insurance. I will be responsible to resolve any billing disputes with my insurance company. Co-payments and deductibles are my responsibility at the **time of service**. I authorize and request payment be made directly to *Shallyn's* by me, the patient or guardian of the patient, under the terms of the insurance policies for services rendered. I understand that the payment for all professional services remains my responsibility, the patient's or guardian of the patient. A balance over 60 days will receive a collection warning. A payment plan can be arranged, however, the first lapse of arranged payment will be sent to collections. I agree to call at least **6 hours** in advance for any cancellations. I understand that a $50.00 fee will be collected for missed appointments or short notice cancellations. (Shallyn's Physical Therapy and Wellness Services will honor unexpected medical and personal exceptions.)

I certify that all statements made by me on this form are true and correct, and that I am duly authorized to furnish this information. I have read this form thoroughly and have resolved any questions regarding its information with the appropriate people.

Patient Name

_____

Signed_____**Date**_____
Patient or Guardian