



NEW LIFE PHYSICAL THERAPY  
AND SPORTS MEDICINE

2639 New Pinery Road Suite 2 Portage, WI 53901  
Phone 608-742-9356 Fax 608-742-9358

**PATIENT INFORMATION (Please PRINT all information)**

Gender: Male Female

Patient name \_\_\_\_\_ If minor, Parent name also \_\_\_\_\_

Patient Social Security # \_\_\_\_\_ If minor, Parent SS# also \_\_\_\_\_

Patient Date of Birth \_\_\_\_\_ If minor, Parent Date of Birth also \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

If P.O. Box, please list street address \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Employer \_\_\_\_\_ If minor, Parent employer \_\_\_\_\_

Work phone # \_\_\_\_\_ If minor, Parent work # \_\_\_\_\_

Referring Physician \_\_\_\_\_

\* Please list today's date \_\_\_\_\_

Is this a workman compensation claim? YES NO Injury date \_\_\_\_\_ \*We MUST have an exact injury date

Is this a motor vehicle accident claim? YES NO Accident date \_\_\_\_\_ State \_\_\_\_\_

*Please note: If you are a workman compensation or motor vehicle accident patient, please be aware that you will be responsible for any outstanding balance that may arise from a denial.*

\*\*\*\*\*

**FOR WORKMAN COMPENSATION OR MOTOR VEHICLE ACCIDENT PATIENTS ONLY:**

Name of workman compensation or motor vehicle insurance to where bills should be sent:

Insurance company \_\_\_\_\_

Claim # \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone number \_\_\_\_\_

*Please be aware that under Wis. Stats. S.102.13 (2) (a), we are required by law to provide the employer, Workman Compensation carrier and the Department with information or written material related to the workman compensation claim. Under these circumstances, a healthcare provider is required to disclose information or documents such as reports and records to the employer that are reasonably related to the workman compensation claim.*



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**FINANCIAL POLICY**

Thank you for choosing New Life Physical Therapy and Sports Medicine as your physical therapy provider. We are committed to providing the best medical care possible.

Please note this is just an **estimated** quote of coverage by your insurance company and does not imply or guarantee coverage at the level stated below. It is always best to check with your insurance carrier to verify your coverage.

**QUOTE OF COVERAGE:** Co payment \_\_\_\_\_; Deductible \_\_\_\_\_; Insurance pays @ \_\_\_\_\_

Please be aware that payment is due at time of service; unless your account is secured with a credit card (debit cards are not accepted). Co payments are collected each visit as required by your insurance company. All monies collected at time of service are **estimated** amounts. The actual amount due may be more or less than what is collected.

Please initial \_\_\_\_\_

**Regarding Health Insurance:** We participate in numerous insurance plans. For most insurances, we accept assignment of benefits but in all cases we require that the guarantor, the person who is financially responsible, to be personally liable for the balance not covered by insurance. (Please be aware that some, and perhaps all, of the services provided may not be completely covered by your insurance company.) We will work with you to determine the extent of your insurance coverage however; **we recommend that you contact your health insurance provider to verify your coverage.**

**Past Due Accounts:** 1 1/2% interest will be added to patient balances over 30 days. If your account becomes overdue, it may be referred to a collection agency and/or lawyer. Legal fees that we pay to secure past due balances will be added to your account. In the event your account is submitted to an outside source for collection, you give your permission to release the necessary information, personal or otherwise, to the outside source and you are aware that this information may become a matter of public record.

**Returned Checks:** A \$35.00 fee will be charged for each check returned to us unpaid by your bank.

**Cancellation/No-Show Policy:** In order to schedule patients with the care that they need, and for the consideration of other patients, New Life Physical Therapy and Sports Medicine requires a 24 hour cancellation notice if a patient is unable to make a scheduled appointment time. **If a patient fails to show up for an appointment or to cancel 24 hours in advance, a \$25.00 fee may be charged to the patient for each missed appointment.** After the first missed appointment, contact between the patient and the clinic will need to be made BEFORE the next scheduled appointment, or all future appointments will be taken off the books to allow for other patient accommodation.

**I have read the Financial Policy and I agree to the terms and conditions outlined within this policy. I hereby consent to medical care and treatment as deemed necessary and proper by the medical staff of New Life Physical Therapy and Sports Medicine, Inc. Furthermore, I agree to assign all health insurance benefits directly to New Life Physical Therapy and Sports Medicine. If the patient is a minor (under age 18), a parent or legal guardian must sign this agreement.**

\_\_\_\_\_  
**PRINT** Patient's Name

\_\_\_\_\_  
Signature of Patient, Parent, or Legal Guardian

\_\_\_\_\_  
Today's Date

Would you like a copy of our HIPPA privacy notice? YES NO Received \_\_\_\_\_ Refused \_\_\_\_\_  
(Please initial on the appropriate line)



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Dear Patient:

Recent changes in the healthcare industry have shifted more of the financial responsibility to the patient through higher deductibles, co-payments and co-insurance. To insure we remain financially viable so that we can continue to provide the best available care to our patients, New Life Physical Therapy & Sports Medicine requires payment of your financial responsibility at the time of service.

However, as a courtesy to you, if you choose to secure your account with a credit card, we will bill you the exact amount your insurance company states is your responsibility once it processes your claims.

**Please check the option you prefer :**

- I will pay an estimated amount, if any, of my patient financial responsibility based upon verification of my health insurance company's explanation of benefits with each visit. I understand that this is just an estimated amount and the actual amount due may be more or less than what is collected. Any overpayment will be refunded upon final processing of all claims.
- Please bill me, but I understand my credit card will be automatically charged for any balance due that is not paid by the due date on my statement. I also understand that if my credit card is due to expire while in treatment, and new credit card information is not supplied before the expiration date, an estimated amount will be applied to my credit card for all past appointments. **Please provide your credit card to the front personnel. (Debit cards cannot be used to secure an account.)**

**I have read the above policy and I agree to the terms that I have checked. I agree to pay the credit card balance in compliance with the cardholder agreement. This agreement shall be in effect until revoked in writing.**

Signed \_\_\_\_\_ Date \_\_\_\_\_

**Please *DO NOT* fill in the following, but bring your credit card to the front desk:**

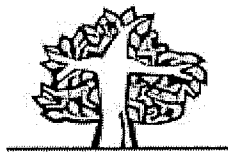
Patient Name (Please print) \_\_\_\_\_

VISA or MASTERCARD (Please circle)

Account Number \_\_\_\_\_ Expiration Date \_\_\_\_\_

3 digit security code on the back of your credit card \_\_\_\_\_ Cardholder zip code \_\_\_\_\_

Cardholder name (Please print exactly as appears on card) \_\_\_\_\_



**Patient Intake Questionnaire**

**New Life Physical Therapy & Sports Medicine**

Portage, WI 53901

Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Age: \_\_\_\_\_ Sex: \_\_\_\_\_

**About your current complaint...**

1 What is the complaint that brought you here? \_\_\_\_\_

2 When did this complaint begin, or recently become worse? Approximate Date: \_\_\_\_\_

3 What caused this complaint? \_\_\_\_\_

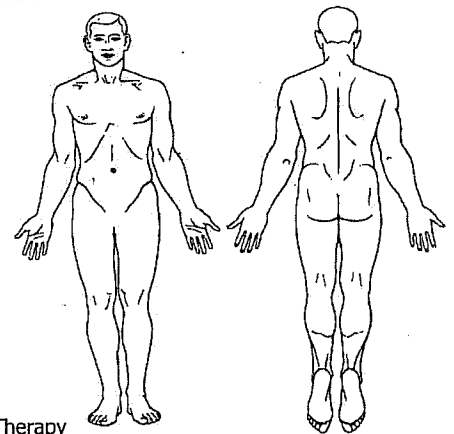
4 Does this complaint affect your activity choice, tolerance, efficiency or effectiveness?  Yes  No

If "Yes", what activities? \_\_\_\_\_

5 What makes this complaint better? \_\_\_\_\_ Worse? \_\_\_\_\_

6 Does this complaint affect your comfort, mood or ability to sleep?  Yes  No

7 What symptoms are you experiencing with this complaint?  
 Swelling  Loss of balance or coordination  
 Loss of motion  Numbness  Pain: Draw pain areas on body diagrams---->  
 Weakness  Tingling  Other (Specify) \_\_\_\_\_



8 How frequent are the symptoms experienced?  
 Constant  Intermittant

9 How much pain are you experiencing?  
 None  Very Mild  Mild  Moderate  Severe  Very Severe

10 What tests have you had for this complaint?  
 XRay  CAT Scan  MRI  Myelogram  Bone Scan

11 What treatment have you had for this complaint?  Physical Therapy  Occupational Therapy  
 Athletic Training  Chiropractic  Alternative Medicine - (Specify): \_\_\_\_\_

12 Is this complaint work related?  Yes  No

If "Yes", your employer's name: \_\_\_\_\_ Your Occupation: \_\_\_\_\_

Work Status:  Full Time  Part Time  Working  Medical Restrictions  Medical Leave Last Date Worked: \_\_\_\_\_

13 Is this complaint auto related?  Yes  No

**About your general health...**

14 Please check all medical conditions that you have, or have had.

- |                                       |  |   |   |   |
|---------------------------------------|--|---|---|---|
| <input type="checkbox"/> Arthritis    | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Stomach Disorder   | <input type="checkbox"/> Fever                        | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Anxiety            | <input type="checkbox"/> Dizziness                    | <input type="checkbox"/> Other: _____                 |
| <input type="checkbox"/> Cancer       | <input type="checkbox"/> Lung Disease        | <input type="checkbox"/> Depression         | <input type="checkbox"/> Nausea / Vomiting            |   |
| <input type="checkbox"/> Diabetes     | <input type="checkbox"/> Thyroid Problems    | <input type="checkbox"/> Panic Attacks      | <input type="checkbox"/> Shortness of Breath          |   |
| <input type="checkbox"/> Stroke       | <input type="checkbox"/> Pace Maker          | <input type="checkbox"/> Change in Appetite | <input type="checkbox"/> Unexplained weight loss/gain |   |

15 Please check all of the following items that currently apply to you.

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Hearing Problems  | <input type="checkbox"/> Pregnant        | <input type="checkbox"/> Bowel or bladder control   |
| <input type="checkbox"/> Visual Problems   | <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> I have had a fall in the past 12 months that resulted in an injury.              |
| <input type="checkbox"/> Learning Problems | <input type="checkbox"/> Smoke           | <input type="checkbox"/> I have had 2 or more falls within the past 12 months in which I was not injured. |

16 Please list surgeries: \_\_\_\_\_

17 Please list allergies: \_\_\_\_\_

18 Please list medications you are currently taking?  
\_\_\_\_\_  
\_\_\_\_\_

19 Are you currently receiving psychological or social services?  Yes  No

Do you want us to help you find a source for such services?  Yes  No

20 What goals do you want to achieve through treatment? \_\_\_\_\_