Donna P. Johnson
Physical Therapy PC

Over 25 years of providing patient focused care
www.DonnaJohnsonPT.com

28 Fourth Street
Fair Haven, VT 05743
Phone: 802-265-4055
Fax: 802-265-8838

153 Main Street, Suite 2
Poultney, VT 05764
Phone: 802-884-8213
Fax: 802-884-8214

If using your health insurance please have the following information available before you call to schedule:

Have you seen us before: ☐ YES ☐ NO

Patient name: _____ DOB: _____

Address: _____

Phone#: _____ Email address: _____

Emergency contact name: _____ Phone#: _____

Primary Insurance Co: _____ ID#: _____ Phone#: _____

Subscriber: _____ DOB: _____ Gender: Female Relation: _____

Secondary Insurance Co: _____ ID#: _____ Phone#: _____

Employer: _____

Address: _____ Phone#: _____

Any physical therapy in your home: ☐ YES ☐ NO

If yes, with what company: _____

Injury area: _____

Referring Dr: _____ PCP: _____

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Name: _____Date: _____

Please list two people we can contact for you in an emergency.

1. Name: _____ Telephone: _____

2. Name: _____ Telephone: _____

Please read this section carefully.

Have you received ANY care in your home this year? _____

Have you received any physical, occupational or speech therapy this year? _____

Are you currently being seen by one of the following:
☐ Chiropractor ☐ Massage therapist ☐ Acupuncturist ☐ Other:_____

Please check if you have had any of these conditions now or in the past.

Past	Present		Past	Present	
☐	☐	high blood pressure	☐	☐	pregnancy
☐	☐	angina	☐	☐	cancer
			Location:_____ Date: _____		
☐	☐	heart attack	☐	☐	tumor
☐	☐	shortness of breath	☐	☐	tobacco use
☐	☐	stroke	☐	☐	drug/alcohol dependence
☐	☐	asthma	☐	☐	headaches
☐	☐	HIV/AIDS	☐	☐	night pain
☐	☐	rheumatoid arthritis	☐	☐	osteoporosis
☐	☐	arthritis	☐	☐	skin condition
☐	☐	systemic lupus	☐	☐	dermatitis/rash
☐	☐	hepatitis	☐	☐	diabetes
☐	☐	epilepsy	☐	☐	other: _____

List of medications

We can copy your list of medications or you may list them below. If you cannot recall the medication name, write down the condition that it is used to treat. Your therapist will review this with you.

_____

_____

Medicare requirement: Height _____ Weight _____

Signature: _____Date: _____

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Patient Authorization Record

Initial below

	Authorization for Treatment • I hereby give authorization for the performance of such rehabilitation procedures as permitted by New York and Vermont statutes under the appropriate scope of practice are, in the judgment of my therapist, deemed necessary.
	Authorization for Release of Information • I agree that Donna P Johnson Physical Therapy PC may provide information from my medical record to persons involved in my medical care. • I authorize the release of medical information necessary to obtain payment of any benefits available to me to Donna P Johnson Physical Therapy PC for services rendered. • I agree that Donna P Johnson Physical Therapy PC may obtain information from others who have provided medical care to me and/or are responsible for the payment of all or part of my bills when this information is needed in order to treat, bill, and/or receive payment. • I have received "Notice of Privacy Practices" mandated by HIPAA.
	Authorization for Release of Payment • I authorize that direct payment of any benefits available to me be released to Donna P Johnson Physical Therapy PC for service rendered.
	Patient Agreement • I agree to pay Donna P Johnson Physical Therapy PC charges for service rendered to me during my course of treatment. • I agree to pay those charges which may not be paid by my health insurance and are my responsibility per my insurance benefit. If I do not pay for charges that are my responsibility, I agree to pay Donna P Johnson Physical Therapy PC collections costs including attorney and court fees.
	Medicare, Medicaid and Similar Benefits • I agree that the information given to Donna P Johnson Physical Therapy PC in applying for benefits under Medicare, Medicaid, and Maternal or Child Health services are complete and accurate. I agree that Donna P Johnson Physical Therapy PC may give Social Security Administration or its fiscal intermediary's information necessary to process claims.

Patient signature or signature of legal representative/POA _____ Date _____

Printed patient name _____ witness signature _____ Date _____

Revised 10-26-2016