



Beth Shelly PT  
1634 Avenue of the Cities  
Moline, IL 61265  
563-940-2481 cell phone  
866-761-7464 fax

**NEW PATIENT INFORMATION:**

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

Patient's Full Legal Name – please provide a copy of your driver's license or other photo identification  
Please complete all sections – print carefully in BLACK ink, Thanks

\_\_\_\_\_  
Last First Middle Initial Sex: Male \_\_\_ Female \_\_\_

Date of Birth: \_\_\_\_\_ Age \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Place a \* on the preferred phone number  
Cell Phone ( ) \_\_\_\_\_ email : \_\_\_\_\_

Patient Status: (check one) Single: \_\_\_ Married: \_\_\_ Other: \_\_\_  
Employment Status: (check one) Employed: \_\_\_ Retired: \_\_\_ Full-time student: \_\_\_ At home mom \_\_\_

Employer's Name and address \_\_\_\_\_

Referring Physician \_\_\_\_\_ Physician Phone number \_\_\_\_\_

Physician address \_\_\_\_\_

Reason for seeking Physical Therapy (Diagnosis) \_\_\_\_\_

**PRIMARY INSURANCE INFORMATION**

Primary insurance company \_\_\_\_\_ Policy number \_\_\_\_\_  
Please provide a copy of your insurance card

Name of Covered Employee: \_\_\_\_\_

Employer Providing Primary Insurance: \_\_\_\_\_

Employer Address: \_\_\_\_\_  
Street City, State, Zip

Relationship to Patient: Self \_\_\_ Spouse \_\_\_ Parent \_\_\_

Insured's name \_\_\_\_\_ Insured's Birthday \_\_\_\_\_

Secondary insurance name \_\_\_\_\_

Secondary insurance policy number \_\_\_\_\_



Privacy Act: I authorize Beth Shelly PT to release medical or other information necessary to provide my treatment and process the claim. I understand this information will not be shared unnecessarily and that my personal information is protected under the Privacy act which this office abides by.

Patient Initials: \_\_\_\_\_

Consent to treat: I consent to physical therapy services at Beth Shelly PT. In doing so, I understand that such therapy may involve bodily contact, touching and / or direct contact of a sensitive nature. I understand that these procedures will be fully explained before they are provided and that I have the right to refuse or stop any treatment at any time without fear of judgment or other repercussions.

Patient Initials: \_\_\_\_\_

Attendance policy: Your success in PT is dependent on regular attendance in therapy. Currently there is a 4 week wait for new patients to start therapy. And I often have a waiting list of patients needing therapy. Please provide 24 hour notice if you are unable to attend. This gives me time to call those on the cancelation list. Failed appointments or those cancelled after 24 hours will be charged a **\$50 cancellation fee**. Repeated failures to attend will result in re-evaluation of your need for therapy. Emergencies or weather cancellations will not be charged the cancellation fee. Please help me to provide the best care possible for you and others.

Patient Initials: \_\_\_\_\_

Statement of Understanding - Notice of Rights for Secure Communication and Waiver of Those Rights  
Federal law requires that this practice use secure/encrypted methods when texting or e-mailing patients. At this time, Beth Shelly PT does not offer a secure/encrypted method to communicate electronically with patients. However, I take patient confidentiality and legal compliance *very seriously*.

- My business phone is a cell phone. This also serves as my home phone.
- I am the only person using the phone, I have no secretary. Occasional you may receive a call from the billing company or my assistant, the phone will always be answered by me.
- I will not be able to answer the phone if I am working with a patient. Please leave a message with your name and phone number.
- When texting, also please make sure to include your name.
- Email is also fine, make sure your full name is included.
- At this time my phone and my email are not secure or encrypted.
- I will make every effort to respond to text, phone messages, and emails within 4 hours during the work day or during the morning of the next business day. Please contact me again if I have not responded in 2 days.

These communications may or may not include private information (such as name, health condition, diagnosis, or billing/financial information). I understand the risks inherent in using unsecured/unencrypted communications. I acknowledge that I may change my preference below at any time by notifying the practice in writing.

Initial only those that apply  
communication

Please place \* on the preferred method of

I authorize this practice to contact me via unsecured text \_\_\_\_\_

I authorize this practice to contact me unencrypted email. \_\_\_\_\_

Please contact me only by phone \_\_\_\_\_

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_