Patient Information

First Name _____ MI _____ Last Name _____

Date of Birth _____ Age _____ SS# _____

Current Mailing Address _____

City _____ State_____ Zip _____ Phone # _____

Gender ☐ Male ☐ Female ☐ Prefer not to answer **Marital Status** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Consent to Communicate by Email

By providing my email address, I understand that authorized personnel of this physical therapy practice may communicate with me regarding scheduling, treatment, health educational and promotional information.

E-mail _____

How did you hear about us?

☐ Doctor ☐ Insurance ☐ Mailing ☐ Family/Friend ☐ Google ☐ Social Media ☐ Returning Patient Other _____

Preferred method of contact: ☐ Phone ☐ Text/SMS ☐ Email ☐ I do not consent to email communications.

Preferred language ☐ English ☐ Spanish ☐ Other _____ ☐ Need a translator

Insurance Information

Billing Information: ☐ I am billing my insurance for these services ☐ I do not have insurance or I would rather pay directly

Do you have Medicare? ☐ Yes ☐ No If yes, are you enrolled in Home Health? ☐ Yes ☐ No

Name of Home Health Agency & Phone Number _____ **Date of Discharge** _____

Have you had Physical Therapy anywhere else this calender year? Y/N If yes, Where _____ **How many visits**_____

Is this visit injury-related? ☐ **Yes** ☐ **No If Yes, check the type:** ☐ **Work** ☐ **Car Accident**

☐ **Other/Personal Injury/Litigation Attorney Name & Phone Number** _____

Health Insurance

Primary Insurance

Insurance Plan _____ Policy ID # _____ Group # _____

Insurance Phone _____ Policyholder Name _____ Relationship _____ DOB_____

Secondary Insurance

Insurance Plan _____ Policy ID # _____ Group # _____

Insurance Phone _____ Policyholder Name _____ Relationship _____ DOB_____

Physician Information

Referring MD Name _____ Phone _____ Next Appt _____

Employer Information

Employer Name/Address _____ Employer Phone _____

Emergency Contact Information

Name_____ Phone_____ Relationship_____

Authorization to Contact & Verbal Communication

☐ I authorize Provider to release protected health information to the following individual(s). Cancellation of this Authorization must be made in writing. Name_____ Relationship_____

Patient Health Questionnaire

Height: _____ft _____ in Weight: _____lbs Referring Physician _____

Symptoms

What problem(s) are you being treated for today? (Describe type and location of symptoms)

_____

What date (roughly) did your present symptoms start?_____

How did your problem(s) begin?_____

Have you had surgery for this injury? ☐ Yes ☐ No Number of surgeries _____ Type of surgery _____

PAIN ASSESSMENT											
Please report a pain assessment on the scale below where 0 is no pain and 10 is the worst pain imaginable.											
	N/A	1	2	3	4	5	6	7	8	9	10
Pain at Rest	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Pain with Activity	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

FUNCTIONAL PROBLEMS	
Please list any and all functional problems you currently have due to your diagnosis.	
1	

Have you had any of the following medical or rehabilitative for this injury/episode? Check all that apply:

Chiropractor	☐	General Practitioner	☐
Massage Therapy	☐	MRI	☐
Occupational Therapy	☐	Neurologist	☐
Physical Therapy	☐	Orthopedist	☐
Emergency Room Care	☐	X-Rays	☐
CT Scan	☐		

Other: _____

Check ALL conditions you have had below if applicable:

Shortness of Breath/Chest Pain	☐	Arthritis/Swollen Joints	☐
Coronary Heart Disease or Angina	☐	Osteoporosis	☐
Pacemaker or defibrillator	☐	Sleeping Problems/Difficulties	☐
High Blood Pressure	☐	Emotional/Psychological Problems	☐
Heart Attack	☐	Vision or Hearing Difficulties	☐
Stroke/TIA	☐	Numbness or Tingling	☐
Blood Clot/Emboli	☐	Dizziness or Fainting	☐
Epilepsy/Seizures	☐	Weakness	☐
Thyroid Trouble/Goiter	☐	Weight Loss/Energy Loss	☐
Anemia	☐	Do you smoke?	☐
Infectious Disease	☐	Are you pregnant? # weeks _____	☐
Diabetes	☐	Had a Major Surgery	☐
Cancer or Chemotherapy/Radiation	☐	Allergies	☐
		If yes, please list _____	

Patient Health Questionnaire (continued)

Medications

Are you currently taking any prescription or non-prescription medications? ☐ Yes ☐ No ☐ List Provided

Med Name	How Much (Dose)	How Often	How Taken (Circle one)
			Ointment Pill Drop Patch Injection Inhaler
			Ointment Pill Drop Patch Injection Inhaler
			Ointment Pill Drop Patch Injection Inhaler
			Ointment Pill Drop Patch Injection Inhaler

Fall History

How many falls? _____ If any, most recent occurrence: ☐ Last 6 weeks ☐ Last 6 months ☐ Last 12 months ☐ More than a year

Consent and Statement of Financial Responsibility

Patient Name: _____ **Date:** _____ **Med Rec #/Account#** _____
(Internal use only)

I hereby consent to the use and disclosure of my health information for treatment provided to me by **of this physical therapy practice**, payment for services provided by the provider or other health care providers and the operations **of this physical therapy practice** and others under certain circumstances. I understand that a more detailed explanation of the ways **of this physical therapy practice** may use and disclose my health information is contained in the Notice of Privacy Practices of the Provider, a copy of which has been provided to me.

PATIENT CODE OF CONDUCT

It is our goal to provide the highest quality of care in a safe environment. In our efforts to achieve this goal, we require all patientsand visitors to refrain from any behavior that may pose a threat to the rights or safety of other patients and employees. Our patients agree to refrain from the following actions: (1) Bringing firearms or other weapons into the clinic; (2) Inappropriate behavior involving alcohol/substance use at time of treatment; (3) Attempting to intimidate or harass in any manner therapists, staff, or fellow patients; (4) Inappropriately touching therapists, staff, or fellow patients; (5) Racial or cultural slurs or other derogatory remarks associated with, but not limited to, race, language or sexuality; (6) Making verbal threats to harm another individual or destroy property through any medium of communication; and (7) Physical assault or inflicting bodily harmViolators of the abovementioned actions may be asked to leave the facility and/or be discharged from the clinic. My signature below indicates that I will support the clinic in its efforts to provide me with quality care in a safe environment and that I understand and accept the terms of the Patient Code of Conduct.

CONSENT FOR TREATMENT

I hereby consent to physical or occupational therapy services deemed medically necessary by my therapist and other health care professional involved in my care. I understand that my physical therapy program may include remote therapeutic monitoring (RTM). RTM services include telephone or video communications from a clinician to review my progress between in-clinic visits. This communication will allow my therapy team to monitor my progress and adjust my home exercise program as necessary to achieve my rehabilitation goals. I will receive complimentary access to the MedBridgeGo© software as well as education to use the app throughout my course of care.

CANCELLATION AND NO SHOW POLICY

Patients are expected to keep all scheduled appointments to maximize the benefits of their treatment plan. If a patient is unable to make a scheduled appointment, the patient is expected to give 24 hours advance notice or may be charged a cancellation fee of $60. Two (2) consecutive appointment no-shows may result in discontinuation of the current appointment schedule for the therapy involved. A pattern of frequent absences (cancellation and/or no-shows) will be considered problematic and result in discontinuation of services. Planned absences from scheduled therapy will not be considered cancellations or no-shows. If a patient provides notice of a planned absence, their on-going schedule may be placed on “hold” for up to two (2) weeks. A renewed prescription and appointment schedule may need to be arranged depending on the length of time which has passed.

TELEPHONE CONSUMER PROTECTION ACT NOTICE

You expressly consent and agree that, in order to discuss or provide services for your account(s) (the "Accounts") or to collect amounts you may owe, this Physical Therapy Practice, and its officers, agents, affiliates, employees, first and third party debt collection agencies, and any affiliated or business associated service providers or vendors of any of these parties, associated therewith (collectively, "We") may contact you by telephone at any telephone number associated with the Accounts, including wireless telephone numbers, which could result in charges to you. You confirm that any telephone number provide is associated with you and not a third-party. You expressly consent and agree that We may also utilize your information to contact you by letters or notices via mail, by sending emails, using any e-mail address you provide to us, by sending text messages or by pre-recorded or artificial voice or voice messages, via predictive or automatic dialing methods, systems, or devices, and pre-recorded or artificial voice announcements or prompts at any telephone number associated with the Accounts, including landlines, wireless or mobile telephone numbers, regardless of whether you incur charges as a result.

Acknowledgment of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have received the Notice of Privacy Practices of this Physical Therapy Practice

This Provider performs automated call, email, and text appointment reminders. The signature below also provides your consent for such reminders.

My signature below indicates that I understand the terms of treatment by this physical therapy practice

Print Patient Name _____ **Date** _____

Signature from Name Above _____ **Date** _____

Guardian Signature (If needed) _____ **Date**

Printed Name of Above (if not patient) _____ **Date** _____

Medicare Secondary Payer *Only complete if you are enrolled with Medicare*

Patient Name: _____ **Date:** _____ **Med Rec #/Account#** _____
(Internal use only)

As a direct result of mandated Medicare Secondary Payer (MSP) regulations, we are required to gather the following information to determine if Medicare is your primary insurance.

1. Is the illness/injury due to an automobile accident, liability accident or Worker's Compensation? ☐ Yes ☐ No
2. Is illness covered by the Black Lung Program or Veterans Administration program? ☐ Yes ☐ No
3. If under 65, are you a renal dialysis patient in your first 30 months of Medicare entitlement? ☐ Yes ☐ No
4. If under age 65, disabled, and covered under an employer's Group Health Plan, does the employer have more than 100 employees? ☐ Yes ☐ No
5. If 65 and over, are you or your spouse employed by a company that has more than 100 employees and are you covered by their Group Health Plan? ☐ Yes ☐ No

INTERNAL USE:
If patient responds "no" to questions 1-5, Medicare is primary. If patient responds "yes" to any questions, Medicare is secondary and primary insurance information must be obtained. **ENSURE INSURANCE INFORMATION IS COMPLETED.**

Home Health Section-REQUIRED

Have you received / are you receiving healthcare services from one of the following:

Skilled Nursing Facility ☐ Yes ☐ No

Home Health Agency ☐ Yes ☐ No

Date Discharged: _____ Do you have a copy of your discharge letter? ☐ Yes ☐ No

Home Health Agency Name _____ Phone # _____

This statement serves as notification that if you are still receiving Skilled Nursing or Home Health services, you may be financially responsible for the treatment received in our clinic.

Protocol for Resolving Medicare Complaints from Medicare Beneficiaries

The patient has the right to freely voice grievances and recommend changes in care or services without fear of reprisal or unreasonable interruption of services. All complaints will be handled in a professional manner. All logged complaints will be responded to in writing or by telephone by a front office manager and investigated by the Compliance Officer within five (5) business days after the receipt of the complaint. If there is no satisfactory resolution of the complaint, the next level of management will be notified progressively and up to an owner of the company.

Patient/Guardian Signature _____ **Date** _____

Third Party Coverage Questionnaire

Patient Name: _____ **Date:** _____ **Med Rec #/Account#** _____
(Internal use only)

INJURY LIABILITY QUESTIONNAIRE

The nature of your injury may alert your medical insurance company to potential liability. Completing this form in its entirety allows this physical therapy practice to provide a quick response to those inquiries and prevent delays in processing your claims.

Is this injury WORK-RELATED? ☐ Yes ☐ No Is this injury AUTO-RELATED? ☐ Yes ☐ No

Have you/do you intend to file a claim against a business or homeowner's insurance policy? ☐ Yes ☐ No

If you answered NO to the questions above, it is not necessary to complete the rest of this form. Please sign and date the bottom of this page.

Injury Information

Date of injury/onset of condition/recent exacerbation? _____

Describe in detail how the injury occurred _____

_____

Specific name and location where injury occurred (i.e.: store, restaurant, intersection, etc.)

_____

_____

Who is responsible for the accident? ☐ Self ☐ Other, describe _____

Insurance of Responsible Party _____ Claim # _____

Address _____

Adjuster Name _____ Adjuster Phone _____

The above information is accurate and true to the best of my knowledge. I agree to immediately notify this physical therapy practice with any change in this information.

Patient Signature: _____ **Date:** _____

When a patient is a minor or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required.

Legal Representative Signature: _____ **Date:** _____

Printed Name (printed) _____

Description of Legal Representative Authority: ☐ Parent ☐ Medical Power of Attorney ☐ Other _____
Explain and Attach Documentation