PHYSICAL THERAPY SPECIALTIES

Date: _____

Patient Registration

PLEASE PRINT

PATIENT INFORMATION

LAST NAME _____ **FIRST NAME**_____

ADDRESS_____

CITY _____**STATE** _____**ZIP** _____

DATE OF BIRTH _____-_____-_____ **AGE** _____

SEX _____

SOCIAL SECURITY NUMER (only for Tricare Patients) _____-_____-_____

HOME PHONE _____-_____-_____ **WORK/CELL PHONE** _____-_____-_____

Okay to leave message? ☐ Yes ☐ No Okay to leave message? ☐ Yes ☐ No

APPOINTMENT REMINDERS

(Check all that are wanted) ☐ **E-Mail** ☐ **Text**

E-MAIL ADDRESS: _____

IN CASE OF EMERGENCY

EMERGENCY CONTACT _____**PHONE** _____-_____-_____

RELATION _____

PRIMARY CARE PHYSICIAN: _____

HOW DID YOU HEAR ABOUT US?

☐ MD ☐ Friend/Family ☐ Internet ☐ Website ☐ Class ☐ 24-Hour Fitness ☐ Other _____

PHYSICAL THERAPY SPECIALTIES

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Health History

1. Do you have any of the following Medical Conditions? ***Please check Yes/No***

GENERAL MEDICAL CONDITIONS:

Arthritis	☐ Yes	☐ No
Anxiety/Panic Disorders	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Depression	☐ Yes	☐ No
Headaches	☐ Yes	☐ No
Hepatitis/AIDS	☐ Yes	☐ No
Incontinence	☐ Yes	☐ No
Osteoporosis	☐ Yes	☐ No
Previous accidents	☐ Yes	☐ No
Sleep Dysfunction	☐ Yes	☐ No
Numbness/tingling in arms/legs	☐ Yes	☐ No
Neurological Disease (i.e. MS or Parkinson's)	☐ Yes	☐ No

Allergies (type)_____

Back Pain (neck pain, low back pain, degenerative disc disease, spinal stenosis)	☐ Yes	☐ No
Gastrointestinal Disease (ulcer, hernia, reflux, bowel, liver, gallgall bladder)	☐ Yes	☐ No
Kidney, bladder, prostate, or urination problems	☐ Yes	☐ No
Prosthesis/Implants	☐ Yes	☐ No
Hearing impairment (hard of hearing, even with hearing aids)	☐ Yes	☐ No
Visual Impairment (such as cataracts, glaucoma, macular degeneration)	☐ Yes	☐ No

Falls within the past year *(only if yes, fill out the Fall Assessment page)* ☐ **Yes** ☐ **No**

PriorSurgery(s)_____

Infection, please describe _____

Recent fractures (broken bones) if so please list _____

Serious injury, explain _____

Allergies to medication, if so please list _____

Major surgery, type _____

Currently pregnant, if so how many weeks _____

List any other history or medical conditions or illnesses _____

_____

_____

HEART DISEASE

Angina	☐ Yes	☐ No
Arrhythmia	☐ Yes	☐ No
Congestive Heart Failure (CHF)	☐ Yes	☐ No
Heart Attack/Myocardial Infarction (MI)	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No

Angioplasty/Coronary Artery Bypass Graft (CABG)	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No
Taking Blood Pressure Medication	☐ Yes	☐ No
Valvular Disease	☐ Yes	☐ No
Heart Problem (other):	☐ Yes	☐ No

please describe**:** _____

LUNG DISEASE

Asthma	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Recent Pneumonia	☐ Yes	☐ No

Chronic Obstructive Pulmonary Disease (COPD)	☐ Yes	☐ No
Acquired Respiratory Distress Syndrome (ARDS)	☐ Yes	☐ No

VASCULAR DISEASE

Diabetes	☐ Yes	☐ No
Stroke/TIA	☐ Yes	☐ No

Peripheral Arterial Disease	☐ Yes	☐ No

PHYSICAL THERAPY SPECIALTIES

Date: _____

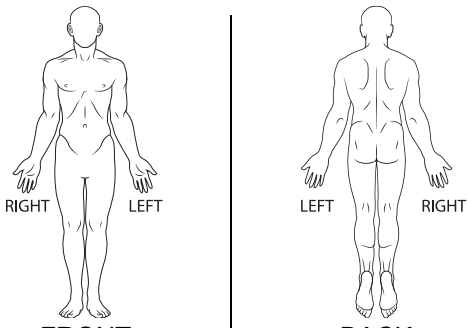
Health History - PAGE 2

REFERRED BY: _____ **PHONE** _____-_____-_____

Date of Injury ____-____-____

If Work Comp, Employer at time of injury _____Phone _____-_____-_____

1. Height: _____ Weight: _____
2. Please indicate on the diagram below the location of your pain and describe the type of pain (sharp, dull, aching, shooting, etc.)



FRONT BACK

3. How did the injury occur?_____

_____

4. Please rate your pain at its lowest, average and highest.
PAIN SCALE: 0-no pain, 1-2-Mild, aware of the pain only when attention is brought to the area. 3-4-Discomforting pain, which may be ignored. 5-Discomforting pain which may be distracting. 6-Distressing pain, but able to perform most tasks. 7-8-Intolerable pain, concentration is difficult, able to perform some tasks. 9-10-Intolerable pain and hospital care is required.

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
1 2 3 4 5 6 7 8 9 10

5. Is your pain: increasing? ☐ decreasing? ☐ same? ☐

6. Have you already received treatment for this problem at other locations? (Please circle)

Medical Doctor	☐ yes ☐ no	Chiropractor	☐ yes ☐ no
Physical Therapist	☐ yes ☐ no	Dentist	☐ yes ☐ no
Psychologist	☐ yes ☐ no	Other _____	

7. What test(s) or treatment(s) have you had concerning this problem? Please check

☐ X-Ray	☐ Myelogram
☐ CT Scan	☐ Cortisone Injections
☐ MR	☐ Biofeedback
☐ EMG	☐ Other, please explain _____

8. Have you had a similar problem in the past? ☐ yes ☐ no

9. Are you currently working? ☐ yes ☐ no If no, last day worked: _____

10. Is there anything else you would like to tell us? _____

PHYSICAL THERAPY SPECIALTIES

Date: _____

Medication Record

Patient Name: _____

Please list all prescriptions, over-the-counter medications, and supplements:
I am taking Vitamin D: ☐ Yes ☐ No

Medication	Dosage	Times per day	Route: (Mouth, injection, patch, etc.)

Date	Changes (dosage changes, discontinued/added medications)	Initials

PHYSICAL THERAPY SPECIALTIES

Date: _____

Consent Form

The following is a list of modalities and procedures used in physical therapy. Your physical therapist will explain which ones will be used during your treatment, discuss treatment alternatives, and goals of treatment with you.

Evaluation
Heat
Ice
Electrical Stimulation
Massage and Muscle Release Techniques
Postural Training
Functional Training
(Body mechanics, Activities of Daily Living)
Ultrasound
Joint Mobilization
Joint Manipulation
Muscle Stretching
Traction
Therapeutic Exercise
Iontophoresis
Biofeedback Training

During your physical therapy it is often necessary to expose or touch the area to be treated. Every effort is made to preserve modesty and keep you comfortable. Our office employs both male and female therapists. Please communicate with our office staff if the gender of your therapist is important to you.

Comments: _____

_____

Consent for Treatment

I give my consent for treatment by the health care professional staff of Physical Therapy Specialties to provide physical therapy and rehabilitation services and necessary treatment as prescribed by my physician. I understand that to evaluate and treat my condition, the physical therapy staff must have visual or physical access to the areas of my body which may be experiencing and/or causing my pain and or dysfunction. I understand that it is my responsibility to immediately communicate any difficulties or concerns that I have regarding my therapy to the staff of Physical Therapy Specialties. I further understand that my physician shall be kept informed regarding my current health status and my response to any treatment received. As with any course of treatment or therapy, there is always the possibility of an unexpected complication and no guarantee or assurance has been made as to the results of treatment.

Patient Signature _____ Date_____

Therapist Signature _____ Date _____

PHYSICAL THERAPY SPECIALTIES

Date: _____

Credit Policy

Our credit policy has 3 options. Please check one of the following

☐ Option 1: You may **self pay** (cash, check or credit card) for each visit which entitles you to a discount. Pay for services is required when rendered, unless other arrangements have been made in advance. Please be prepared to pay for each visit at the time of service.

☐ Option 2: **Work related injury**. Worker's compensation insurance will be billed. No payment is collected from you. Services for industrial injuries must have prior authorization by the industrial carrier. You will be informed if any difficulties in obtaining authorization are encountered. The patient is responsible for all fees should the industrial insurance company deny authorization for treatment.

☐ Option 3: **Private Insurance**:
If your bill is to be paid by a third party, for example an insurance company, it is required that you sign an Assignment of Benefits (See Patient Registration) so that the insurance company can pay us directly. It will be your responsibility to pay the portion of your bill not covered by your insurance company at the time of service (example: deductible, co-payment, share of cost 20%, etc.). The patient is ultimately responsible for all fees regardless of insurance coverage. We will make every effort to provide only those services considered medically necessary by your insurance plan, unless your express permission is given in writing. Should your insurance plan deem that services are not medically necessary, you will be responsible for the charges.

I understand that it is my responsibility to follow the guidelines and to know the coverage and benefits of my medical insurance plan. If I am a member of a managed care program, it is my responsibility to notify Physical Therapy Specialties that my plan requires referrals and to obtain all referrals in advance of services rendered. I understand that I am financially responsible for all services for which I have not obtained a valid referral. I further agree that a photocopy of this agreement shall be as valid as the original.

Note: **24 hour notice is required to cancel an appointment. If notice is not given you may be subject to a late cancellation charge of $50.00. You will be charged the $50.00 fee if you fail (or "no show") to keep your appointment.**

Initials: _____

ASSIGNMENT OF BENEFITS

I understand that payment for service is expected at the time service is rendered unless my insurance is to be billed. I understand that I am financially responsible for all charges whether or not they are paid by my insurance. I hereby authorize Physical Therapy Specialties to release all information necessary to secure the payment of benefits. I authorize my insurance benefits to be paid directly to Physical Therapy Specialties.

I have read the above, understand it and agree to it.

_____ _____

Signature Date

PHYSICAL THERAPY SPECIALTIES

Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices

Physical Therapy Specialties reserves the right to modify the privacy practices outlined in the notice. I understand that Physical Therapy Specialties may contact me to remind me of appointments or to discuss any other health related manner.

_____ _____
Signature Date

_____
Print Name

_____ _____
Signature of Patient Representative Date
(Required if the patient is a minor or an adult who is unable to sign this form)

_____
Relationship of Patient Representative to Patient

Privacy practices are posted in our reception area. A copy is available for you to review at any time by asking the Receptionist. We are diligent in ensuring client privacy is maintained at all times.

PHYSICAL THERAPY SPECIALTIES

Date: _____

Patient Electronic Communication Consent Form

Physical Therapy Specialties (PTS) offers patients the opportunity to communicate by email. Sending patient information includes several risks of which the patient should be aware. The patient should not agree to communicate with PTS staff via email without understanding and accepting these risks.

The following summarizes the information you need to determine whether you wish to supplement your healthcare experience at our practice by electronically communicating with staff members.

General Considerations

- E-mail communication will be considered and treated with the same degree of privacy and confidentiality as written medical records.
- Standard e-mail services, such as Gmail, AOL, Yahoo and Hotmail are not secure. This means that the e-mail messages are not encrypted and can be intercepted and read by unauthorized individuals.
- Transmitting e-mail that contains protected health information through an email system that is not encrypted does not meet the security guidelines as required by the Health Information Protection and Accountability Act (HIPAA).
- Your e-mail address will not be used for external marketing purposes without your permission. You may receive a group mailing from the practice, however, the recipients e-mail addresses wil be hidden.

Provider Responsibilities

- All e-mail/text communication with patients is sent via a non-encrypted service, therefore information is not secure.
- Your provider may route your e-mail messages to other members of the staff for informational purposes or for expediting a response.
- Designated staff may receive and read your e-mail.
- Copies of e-mails sent and received from and to you will be incorporated into your medical record. You are advised to retain all electronic correspondence for your own files.
- Emails will be utilized for insurance verification, surveys, as well as appointment reminders and scheduling. The provider will attempt to electronically confirm your e-mail address by requesting a return response to all email messages.

Patient Responsibilities

- E-mail messages should not be used for emergencies or time sensitive situations. In the event of a medical emergency, you should contact 911. For emergent or time sensitive situations, you should contact your healthcare provider through the office, via telephone.
- Please key in your full name and the topic, i.e., home program question, in the subject line. This will serve to identify you as the sender of the e-mail.
- Please acknowledge that you received and read the provider's message by return e-mail to the provider.

I have read and understood the above description of the risks and responsibilities associated with the electronic communication with my healthcare provider.

PHYSICAL THERAPY SPECIALTIES

Date: _____

- I acknowledge that commonly used e-mail services are not secure and fall outside of the security requirements set forth by the Health Insurance Portability and Accountability Act for the transmission of protected health information.
- I understand that I may revoke my consent to communicate electronically at any time by notifying Physical Therapy Specialties in writing, but if I do, the revocation will not have any effect on actions my healthcare provider has already taken in reliance on my consent.
- I agree to release my provider and the practice from any and all liability that may occur due to electronic communication over a non-secured network.
- I further agree to be held accountable for the patient responsibilities as outlined above.

PATIENT_____

Patient Authorized E-mail Address _____

Patient Signature_____

Date_____

Patient Representative (if applicable) _____

Patient Representative E-Mail Address _____

Patient Representative Signature_____

Date_____