# FAMiLY & SPORTS PHYSICAL THERAPY

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orthopaedics • wellness • sports medicine

## PATIENT INFORMATION

**Name**_____ **Age**_____ **Weight**_____ **Height** _____

**Occupation**_____ **Currently working?** Yes No

**Emergency Contact Name**_____ **phone number**_____

**FOR YOUR PRESENT INJURY OR PROBLEM** (What you are coming into physical therapy for)

1. How did this injury or problem occur?_____
2. Date of onset or injury?_____
3. Did you have surgery? (if yes, when?)_____
4. Have you had this problem before? Yes No
   If yes, please describe when, treatment_____
5. Please list how this problem affects your daily activities:_____
   _____

**CURRENT AND PAST MEDICAL HISTORY** (please circle yes or no)

| | | | | | |
|---|---|---|---|---|---|
| Cancer | yes | no | Osteoarthritis | yes | no |
| High Blood Pressure | yes | no | Rheumatoid Arthritis | yes | no |
| Heart Attack | yes | no | Kidney disease | yes | no |
| Heart Disease | yes | no | Epilepsy | yes | no |
| Pacemaker | yes | no | Seizure | yes | no |
| Diabetes - Type I or II | yes | no | Hepatitis | yes | no |
| Stroke | yes | no | Thyroid problems | yes | no |
| Asthma | yes | no | Tuberculosis | yes | no |
| Emphysema | yes | no | Drug Dependency | yes | no |
| Multiple Sclerosis | yes | no | Alcoholism | yes | no |
| Anemia | yes | no | Pregnant (NOW) | yes | no |
| Osteoporosis | yes | no | OTHER_____ | | |

**Please describe any other relevant problems**_____
_____
_____

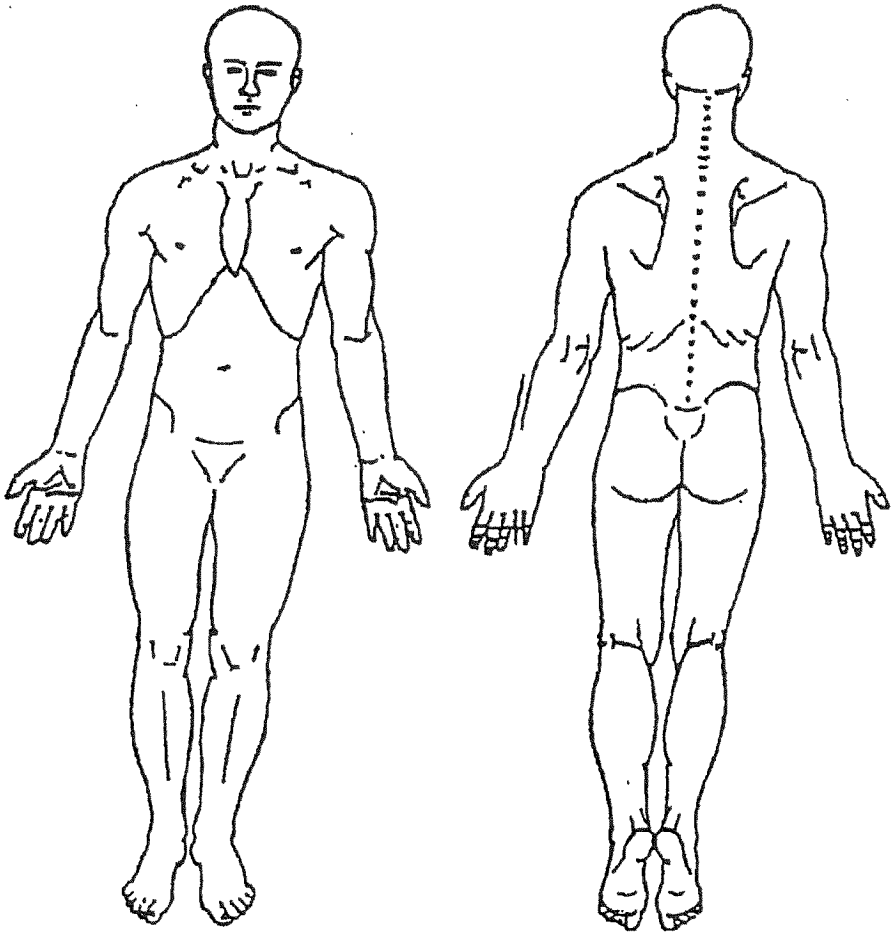
**Please list any medications that you are taking:**_____
_____
_____

**Patient or Guardian Signature**_____ **Date** _____

# Symptom Diagram

PLEASE MARK THE AREA (S) ON THE DIAGRAM CORRESPONDING TO YOUR CURRENT SENSATIONS USING THESE SYMBOLS:

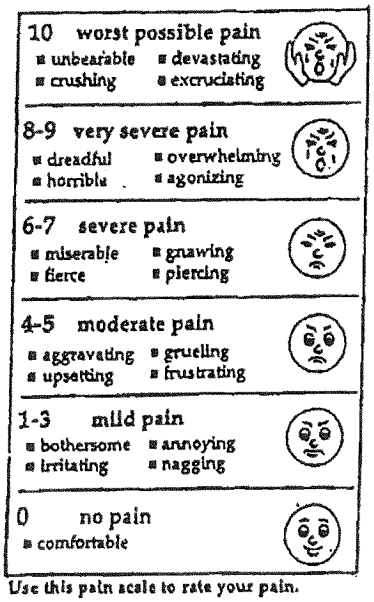
| Stabbing | Burning | Pins & Needles | Numbness |
|---|---|---|---|
| /// | XXX | OOO | = = = |



PLEASE INDICATE YOUR CURRENT PAIN LEVEL? (Draw a vertical line)

No Pain |——————————————————————| Worst Possible

Please rate your pain using a scale from 0-10 (0=no pain, 10= Severe pain) 1. At this time_____, 2. At its worst_____, 3.At its best_____.




Use this pain scale to rate your pain.

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# FINANCIAL POLICY

We are committed to providing you with the best possible care. If you have medical insurance, we are happy to help you. In order to achieve this, we need your assistance and your understanding of our policy.

We will be happy to assist you with getting your claims submitted for reimbursement.

Returned checks are subject to additional fees. Charges may also be made for "No Show" appointments and appointments canceled without 24 (working) hours advance notice.

You must realize, however, that:

1. Your insurance is a contract between you, your employer, and the insurance company. We will render service on the assumption that charges will be paid by the insurance company; however, you are responsible for the deductible, co-pays, or percentage not covered by your insurance.
2. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
3. This office understands special needs. It may be necessary to set up a payment plan for a patient. If this situation is necessary for you or arises as a temporary financial problem that may affect timely payments, please contact our billing office promptly for assistance in the management of your account. The billing office telephone number is 897-5283.
4. If the insurance company has failed to pay for subsequent appointments within a 45 day period, we will expect you to make a payment on your account and follow-up with your insurance.
5. If your account is turned over to a collection agency, we may assess up to a 50% collection fee.

We must emphasize that as a medical care provider, our relationship is with you, not your insurance company.

If you have any further questions about the above information, please don't hesitate to ask us. WE ARE HERE TO HELP YOU!!!

I HAVE READ THE ABOVE INFORMATION AND UNDERSTAND THE FINANCIAL POLICY OF THIS OFFICE.

_____
**PRINT NAME**

_____ _____
**SIGNATURE** **DATE**

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# CONSENT TO TREATMENT

I understand that I have been referred to Family and Sports Physical Therapy for a physical therapy evaluation and treatment. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, and during the course of my treatment, including any risks or alternatives to the treatment plan that has been prescribed by my physician and/or recommended by my therapist. By signing this agreement, I consent to have Family and Sports Physical Therapy evaluate, provide treatment and care as prescribed by my physician and/or recommended by my therapist.

_____

Print Name

_____ _____

Signature Date

## CANCELLATION, TARDINESS, AND NO SHOW POLICY

Attendance to scheduled therapy appointments is important for your rehabilitation program, as well as helping us keep a smooth running facility. Appointment times are given in a way to try to provide any optimal amount of time for each patient. If you are late (or very early) for your scheduled appointment, we will try to get you started as soon as possible. If you must cancel, we ask that you give us a call and let us know so that we can try to accommodate another patient who may be waiting for an appointment. If you cancel frequently, we may ask you to schedule only one appointment at a time so that time-slots can be filled by other patients. If cancellations continue, your therapist may discharge you. No Shows (not coming in or calling to cancel) for appointments affect our business, as well as waste an appointment time that someone else could have used. If you No Show for 3 consecutive visits, or regularly No Show for visits on consecutive weeks, your therapist will discharge you.

Thank you very much for your cooperation.

I have read and understand Family and Sports Physical Therapy's policy on cancellation, tardiness, and No Shows.

_____

Patient Signature

FAMILY & SPORTS PHYSICAL THERAPY

**HIPAA Form**

Patient consent to the use and disclosure of health information for treatment, payment or healthcare operations as required by the federal government.

I, _____, understand that as a part of my healthcare, Family & Sports Physical Therapy originates and maintains paper and/or electronic records describing my healthcare history, symptoms, test results, examination, diagnoses, treatment and any plans for future care of treatment. I understand that this information serves as:

- Basis for planning my care and treatment.
- Means of communication among the many healthcare professionals who contribute to my care.
- Source of information for applying diagnosis and treatment information for billing.
- Means by which a third party payer can verify that services billed were completed as charged and,
- Tools for routine healthcare operations such as assessing quality and reviewing the overall quality of your care.

I understand and have received a notice of information practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations.

I understand that Family & Sports Physical Therapy is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by section 164.506 of the code of federal regulations.

I further understand that Family & Sports reserves the right to change their notice and practices, and prior to implementation, in accordance with section 164.520 of the code of federal regulations. Should Family & Sports change their notice, they will send a copy of any revised notice to the address I have provided. I wish to have the following restrictions to the use or disclosure of my health information: _____

_____.

I understand that as a part of this organizations treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax and/or e-mail.

I fully understand and ◯ ACCEPT ◯ DECLINE the terms of this consent.

_____

Patient's Signature Date

◯ Received by:_____on_____ ◯ Patient refused consent/treatment refused:_____