Pain Relief and Physical Therapy

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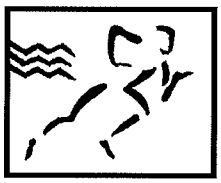

PATIENT INFORMATION FORM

Date of Evaluation _____ **PT**_____

Pre cert info:

Last Name, First _____, _____,**DOB:**__/__/____**E mail:**_____
Parent/Guarding (if under 18) Last Name, First _____,_____**DOB:**__/__/_____
HOME#_____
Insurance Type:_____**Ins. ID #** _____**Group #**_____
Insurance Member Services Phone Number (back of ID card) (____)____ - _____

MVA: Y / N Ins.:_____ **Claim#**_____**Contact:**_____**Date of Accident:**____
WC: Y / N Ins.:_____**Employer:**_____**Contact:**_____ **Date of Injury:**_____

Do we have your permission to call the above phone # to remind you of IE **Y____ N _____**

Patient info:

Address_____
City_____State_____Zip_____
Work Phone: (___)-_____Cell: (___)-_____ SS#_____-_____-_____ Age:_____

Referring Physician:_____Date of next visit with Referring Physician:_____
Office Location:_____
Primary Physician:_____ Office Location:_____Phone #:(____)_____

Would you like copies of your reports sent to your Primary Physician? **Y** **N**

Whom may we thank for your visit? _____

What is your chief complaint? _____

DATE OF ONSET: of injury/problem/surgery: _____

Have you had X-Rays, CT Scans, MRIs, Bone Scans or other diagnostic tests for your recent disorder? **Y** **N**
If yes, please explain findings as you understand them. (We would appreciate copies of any reports you may have)

Have you had any Physical Therapy/Occupational Therapy in the last Year ? **Y** **N**

What are your goals for rehabilitation? _____
_____

FINANCIAL POLICY

Patient's with Insurance Coverage: We thank you for choosing Pain Relief and Physical Therapy, Inc to provide your rehabilitation needs. As a courtesy to you, we will be glad to help you obtain the appropriate benefit from your insurance carrier and we will bill your carrier. **The service you have elected to participate in implies a financial responsibility on your part.** This responsibility obligates you to ensure payment in full of our fees and you are ultimately responsible for payment of your bill. We will be happy to request a pre-estimate of benefits from your insurance carrier if you request us to do so. Most insurance companies generally cover routine Physical/Occupational Therapy, but full payment is not guaranteed. Portions of the bill may not be paid by the insurance company and have to be paid by the patient. **If your insurance carrier deems these services to not be medically necessary, than you will be responsible for payment of each visit at a rate of seventy dollars per visit.** Typically, there is a CO-PAYMENT or annual DEDUCTIBLE as per your insurance agreement.
Patients without insurance coverage: are requested to pay for services as rendered.
I have read the above Financial Policy regarding my financial responsibility to Pain Relief and Physical Therapy, Inc. for providing rehabilitation services to me, or the above named patient. I certify that the information I have provided is, to the best of my knowledge, true and accurate. I authorize my insurer to pay Pain Relief and Physical Therapy, Inc. the full and entire amount of the bill incurred by me, or the above patient.

Patient/Guardian Signature: **Date:**

CONSENT FOR TREATMENT AND AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Pain Relief and Physical Therapy, Inc., through its appropriate personnel to perform or have performed upon myself for the above named patient, the appropriate examination and treatment procedures relating to the condition(s) for which therapy is sought. I further authorize Pain Relief and Physical Therapy, Inc. to release to the appropriate agencies, any information acquired in the course of my, or the above named patient's, examination and treatment.

Patient/ Guardian Signature: **Date:**

NO SHOW/CANCELLATION POLICY

Your therapist reserves a specific time for your appointment. We understand that there may be times when you must miss an appointment, but a minimum of 24 hours notice is required if you need to cancel an appointment. When you call you will be asked to reschedule. FOR SATURDAY APPOINMENTS: any missed or cancelled appointments with less than 24 hours notice will result in a charge of $25 that is not billable to your insurance.

Patient/Guardian Signature: **Date:**

PRIVACY PRACTICES AKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient/Guardian Signature: **Birth date:** **Date:**

Patient Name: _____ Date: _____

Please describe any significant injuries, for which you had been treated (including fractures, Dislocations, sprains) and approximate date of injury:

DATE	INJURY	DATE	INJURY

Has anyone in your immediate family (parents, brothers, sisters) ever been treated for the following:

Y	N	Diabetes	Y	N	Kidney Disease	Y	N	Epilepsy	
Y	N	Tuberculosis	Y	N	Cancer	Y	N	Mental Illness	
Y	N	Heart Disease	Y	N	Arthritis	Y	N	Alcoholism/Chemical	
Y	N	High Blood Pressure	Y	N	Anemia			Dependency	
Y	N	Stroke	Y	N	Headaches				

Which of the following OVER THE COUNTER medications have you taken in the last week?

Y	N	Aspirin	Y	N	Weight Gain/Loss
Y	N	Tylenol	Y	N	Nausea/Vomiting
Y	N	Advil/Motrin/Ibuprofen	Y	N	Fatigue
Y	N	Laxatives	Y	N	Weakness
Y	N	Decongestants	Y	N	Fever/Chill/Sweats
Y	N	Antihistamines	Y	N	Numbness or Tingling
Y	N	Vitamins/Mineral supplements	Y	N	Bowel/Bladder Problem
Y	N	Other			

Please list any PRESCRIPTION medications you are currently taking (INCLUDING pills, injections, and/or skin patches):

1._____ 2._____

3._____ 4._____

5._____ 6._____

How much caffeinated coffee or caffeine containing beverages do you drink per day? _____
How many packs of cigarettes do you smoke per day? _____
How many days per week do you drink alcohol? _____
If one drink equals one beer or glass of wine, how much do you drink at an average sitting? _____

To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you do not understand a question, leave it blank and your therapist will assist you. Thank You!

Patient's Name _____DOB:_____Occupation:_____

Leisure Activities/Sports/Hobbies:

_____

Allergies: List any medication(s) you are allergic to:

_____

Are you latex sensitive: Yes No List any other allergies we should know about

_____

Please check any of the following who care you're under

_____Physician (MD, DO) _____Psychiatrist/Psychologist _____Chiropractor
_____Dentist _____Physical Therapist _____Other _____

If you have seen any of the above in the past three months, please describe for what reasons (illness, medical condition, physical, etc)

Have you EVER been diagnosed as having any of the following conditions?

Y	N	Cancer	Y	N	Other arthritic conditions
Y	N	Heart Problems	Y	N	Depression
Y	N	High Blood Pressure	Y	N	Hepatitis
Y	N	Circulation Problems	Y	N	Tuberculosis
Y	N	Kidney Problems	Y	N	Stroke
Y	N	Nervous Disorders	Y	N	Kidney Disease
Y	N	Asthma	Y	N	Anemia
Y	N	Emphysema/Bronchitis	Y	N	Epilepsy
Y	N	Chemical Dependency	Y	N	Osteoporosis or Osteopenia
Y	N	Thyroid Problem	Y	N	Diabetes
Y	N	Rheumatoid Arthritis	Y	N	Multiple Sclerosis
Y	N	Other			

Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization.

Date:	Reason for surgery/hospitalization	Date:	Reason for surgery/hospitalization

Therapist Signature: _____ **Date:** _____

Patient Signature: _____ **Date:** _____