

Hands On Physical Therapy

Myofascial Release, Pain Relief, Headaches,
Neck/ Back pain, Women's Health

PLEASE PRINT AND COMPLETE ALL ENTRIES

PATIENT INFORMATION

NAME (LAST, FIRST, MI) _____

ADDRESS _____

CITY _____ ST _____ ZIP _____

HOME # _____ CELL# _____ WORK# _____

EMAIL (TO RECEIVE UPDATED EVENTS AND NEWS) _____

DOB: _____ SS# _____ MARITAL STAT S M W D

PHYSICIAN NAME _____ ADDRESS/ PHONE# _____

EMERG. CONTACT _____ PH# _____ RELATIONSHIP _____

EMPLOYER INFORMATION (OF INSURED PERSON)

EMPLOYER _____ PHONE: _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

INSURANCE INFORMATION

**TO ASSURE PROPER FILING OF YOUR CLAIMS, PLEASE PROVIDE YOUR CARD SO THAT WE
MAY COPY IT FOR OUR RECORDS**

INSUREDS NAME _____ DOB _____ SS# _____

INSURANCE CO. _____ PHONE # _____

INSURANCE ADDRESS _____

GROUP# _____ ID# _____ RELATION _____

I, _____, have read a copy of the privacy practices. (This document is available at our front desk).

_____ (initial) **CANCELLATION POLICY**

If the patient cannot adhere to a scheduled appointment, it is the patient's responsibility to call the office to cancel within 24 hours of the scheduled appointment. A fee of \$65.00 will be charged for the first appointment canceled less than 24 hours and \$135.00 for each subsequent appointment. If you sign up for a class and do not cancel with 24 hours of your class, you will be charged \$25.00 per class.

_____ (initial) **RELEASE OF MEDICAL INFORMATION**

I do / I do not (circle one) authorize Hands on Physical Therapy to release medical information to my spouse, parent or guardian.

_____ (Initial) **Contact Permission**

In the event that Hands on Physical Therapy needs to contact you (patient) regarding appointments, billing, treatment or any other reason, it is permissible to:

- Leave a message on the answering machine. Phone # you wish us to call _____
- Speak with a spouse/significant other.
- Speak with other family members.

_____ (initial) **CONSENT TO TREATMENT**

I consent to the performance of examinations, and rendering of treatment by the medical provider and their designated medical office staff as is deemed necessary in the medical provider's judgment.

_____ (initial) **AUTHORIZATION / ASSIGNMENT / FINANCIAL RESPONSIBILITY**

I authorize the release of any medical information necessary to process an insurance claim on my behalf. I understand that I am financially responsible for all charges and that I am responsible for obtaining any referrals required by my insurance carrier. I request that my medical insurance/automobile insurance carrier make payment directly to Hands on Physical Therapy for services rendered to me. As a courtesy, my charges will be filed with my insurance carrier; however, I will be billed if the claims are denied or are not paid in a timely manner. Should my account become a collection problem, additional charges may be incurred.

My signature below indicates that I have read and am in agreement with all statements that I have initialed above.

Signature of Patient (or guardian)

Date

AUTHORIZATION FOR TREATMENT

I authorize the Healthcare Provider to administer treatment as deemed necessary or advisable in the diagnosis and treatment of any condition related to the patient consistent with, Advance Directive, Living Will or Durable Power of Attorney for Healthcare of file.

ASSIGNMENT OF BENEFITS, PAYMENT TERMS AND RELEASE OF INFORMATION

As the Guarantor of this account, I agree to assign to Hands on Physical Therapy all insurance benefits otherwise payable to the patient or insured for services rendered. I agree to be held financially responsible for services rendered by Hands on Physical Therapy that are not covered by my insurance company. I understand that it is my responsibility to notify the provider of any changes in insurance coverage. I know that I will pay the balance owed if the insurance or personal information I have given is not true.

I authorize the release of pertinent medical records to the patient's insurance carrier for the purpose of claims payment. I understand that this applies to all types of insurance coverage, including but not limited to Medical, Worker's Compensation and Liability/Auto. I understand that the only records released would be pertinent to the date of service and to the carrier providing the coverage for that date of service. Failure to provide this authorization may result in the insurance carrier's denial of a claim. I have been given a copy of the practice's Financial Policy when applicable and understand its content.

I also have the right to request a copy of the Notice of Privacy Practices at anytime.

Signature: _____

Date: _____

Patient Name: _____

Date: _____

INITIAL EVALUATION SUBJECTIVE REPORT

THE FOLLOWING IS VERY IMPORTANT IN OUR EVALUATION PROCESS. PLEASE FILL OUT THESE FORMS AS SPECIFICALLY AS POSSIBLE TO PROVIDE US WITH A CLEAR PICTURE OF YOUR PRESENT PAIN AND FUNCTIONAL STATUS.

IN THE SPACE BELOW, DESCRIBE YOUR SYMPTOMS SPECIFICALLY.

1. What is your primary complaint that brings you to P.T.?

Secondary Complaint?

2. Have you ever received the following treatment for the condition mentioned above?

	Yes	No	How Long	Helpful
Physical Therapy	_____	_____	_____	_____
Myofascial Release	_____	_____	_____	_____

3. What date did your symptom(s) begin?

4. How did your symptom(s) begin?

5. On a scale of 1-10 rate your intensity of pain.
(1-No Pain 5-Moderate 10-Worst Pain Imagineable)

Please Circle Only One

1 2 3 4 5 6 7 8 9 10

Rate the Frequency of your pain

Times per week _____ Daily Hourly Constant

5. At what time of the day are your symptoms the worst? _____

At what time of the day are your symptoms the best? _____

6. Do you have trouble falling asleep? Yes No
- Is your sleep restful? Yes No
- How many times do you wake in the night? _____
- How long before you fall back to sleep? _____

6. What activities increase your pain?

7. What activities decrease your pain?

8. Do you have any of the following medical conditions?

<u>Condition</u>	<u>Yes</u>	<u>No</u>
Circulatory Problems	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
Blackouts	<input type="checkbox"/>	<input type="checkbox"/>
Visual Disturbances	<input type="checkbox"/>	<input type="checkbox"/>
Weight Change (more than 15 pounds)	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>
Bowel and Bladder Problems	<input type="checkbox"/>	<input type="checkbox"/>
Malignancy	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>

9. List past medical history and dates of occurrence. (Include surgeries, accidents and other traumas.)

10. For each activity listed below, please note the amount of time in minutes or hours that you can perform before you feel that you need to stop because of you symptoms. If you have no difficulty with the activity, mark **OK**. If you are unable to perform the activity, mark **UNABLE**. If this does not apply to you mark **N/A**.

Activity	Tolerance	Activity	Tolerance
Sitting		Computer work	
Standing		Exercise	
Walking		Writing	
Stairs (# of stairs)		Shopping	
Driving		Bending	
Sleeping		Reaching (reps)	
Lifting (pounds)		Carrying (pounds)	
Housework			

11. Please list your SHORT TERM GOALS.

12. Please list your LONG TERM GOALS.

Body Diagram

Please circle any pain areas, even if you feel they are unrelated to your diagnosis or chief complaint.

