PHYSICAL THERAPY OF CUMBERLAND
Achieve Your Goals

Name _____ DOB ____/____/____
Street Address _____
City _____ State _____ Zip _____
Home Phone # _____ Cell Phone # _____
Email _____
Would you like an appointment reminder: □ YES □ NO
If yes, please check the appropriate box: Email □ ***OR*** □ Text Message _____
(wireless carrier)

Emergency Contact _____ Relationship _____
name *phone*

Primary Insurance _____
ID Subscriber Number _____ Group # _____
Policy Holder Name _____ DOB ____/____/____
Secondary Insurance _____
ID Subscriber Number _____ Group # _____
Policy Holder Name _____ DOB ____/____/____

Is injury work related? Yes _____ No _____
If yes, what was Date of Injury? ____/____/____
Employer Name _____ Phone Number _____
Workers Compensation Insurance Name _____
Workers Compensation Insurance Address _____
City _____ State _____ Zip _____
Workers Compensation Insurance Contact Person _____
Phone Number _____
Claim Number _____

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OFFICE POLICIES AND PROCEDURES

We have developed this information to make you aware of our billing policies at the time of your initial office visit. Please review these policies carefully.

Physical therapy services are reimbursed under the provisions of most health insurance policies. **You, as the subscriber, are primarily responsible for knowing the terms of your policy**. Our office personnel are familiar with various coverages offered by health insurance companies, and will assist you. If you (the subscriber) should receive a check from your insurance company that is intended for this practice (the provider) for services rendered, you should immediately remit this to our office for credit to your account. Failure to do so will result in our office billing you for the complete balance and you will be responsible for payment of this amount in full.

Liability cases are accepted when accompanied by a health insurance plan and/or auto insurance with a medpay plan. We will accept the insurance plan's allowable, along with the copays and/or deductibles, as payment in full for any covered services rendered to our patients. However, once the health insurance plan indicates that it will no longer pay for physical therapy benefits the service will no longer be considered a covered service.

Worker's compensation patients will be accepted according to the Worker's Compensation Law enacted in 1992. Should your claim be denied by your Worker's Compensation company, we will bill your medical insurance carrier and you will be responsible for any deductibles and co-payments. If you do not have a third party insurance, please speak with the Billing Supervisor to make arrangements for payment of your account. Failure to attend physical therapy may jeopardize your worker's compensation benefits.

Medicare patients who do not have supplemental insurance will be billed for their yearly deductible and 20% of the Medicare allowable. If Medicare denies payment, the patient will be billed for 100% of the allowable.

Medicaid does not pay for physical therapy in a private practice.

If this is a Worker's Compensation case, please make sure you have informed the front office.

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NO SHOW AND CANCELLATION POLICY

Your scheduled appointment is reserved for you. **If you are unable to keep your appointment, you must cancel at least twenty-four (24) hours in advance. If you neglect to cancel your appointment, a $50 fee will be charged to your account.** If you are going to be late for your appointment, you should call to inform us of your expected arrival time. Your appointment may need to be rescheduled at the discretion of the physical therapist, to ensure that your late arrival will not interfere with the treatment of the patient scheduled after you.

_____ _____

(*Signature of patient or parent/guardian)* *(Date)*

CO-PAYMENTS are due at time of service. Please contact the customer service department of your insurance company for information regarding your Out-Patient Physical Therapy Benefits and co-payment amount. Thank you!

CO-PAYMENTS (estimate per your insurance contract):

Initial Evaluation with Treatment: $_____ Notes: _____

Each Follow-up: $_____ _____

_____

I, _____, fully understand the contents of your office policies and
(*please print)*
procedures and agree to abide by them. I also agree to pay for the charges that may be made towards my account for physical therapy services rendered by this office, consistent with the terms of my health insurance policy.

_____ _____

(*Signature of patient or parent/guardian)* *(Date)*

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DESIGNATED INDIVIDUALS AUTHORIZATION FORM

I authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name:_____ Relationship: _____

Name:_____ Relationship: _____

AUTHORIZED SIGNATURE FORM

- I request that payment of insurance benefits for services rendered to me be paid directly to Physical Therapy of Cumberland.
- I authorize Medicare to send claims to my secondary insurance for crossover benefit payments.
- I authorize Physical Therapy of Cumberland to release medical information to my insurance carrier to determine benefits payable.
- I understand that I may revoke this authorization at any time with a renewed and dated signature

My insurance is:

Primary_____

Secondary _____

_____ _____

Signature *Date*

I wish to revoke the above release for payment/release of medical information

Signature_____ Date_____

NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

Physical Therapy of Cumberland's Legal Duty

Physical Therapy of Cumberland is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Physical Therapy of Cumberland uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, Physical Therapy of Cumberland may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Physical Therapy of Cumberland may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, Physical Therapy of Cumberland's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may revoke that authorization to stop future disclosures at any time.

Physical Therapy of Cumberland may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment, or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. Physical Therapy of Cumberland will consider all such requests on a case-by-case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that Physical Therapy of Cumberland may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager. You may also send a written complaint to the US Department of Health and Human Service.

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I have read and fully understand Physical Therapy of Cumberland's Notice of Information Practices. I understand that Physical Therapy of Cumberland may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Physical Therapy of Cumberland will consider requests for restriction on a case by case basis but does not have to agree to requests for restrictions. I hereby consent to the use and disclosure of my personal health information for purposes as noted in Physical Therapy of Cumberland's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Sincerely,

The Staff of Physical Therapy of Cumberland

_____ _____

Patient Signature *Date*

_____ _____

Physical Therapists Signature *Date*

PAST MEDICAL HISTORY

Please fill out front & back.

Name: _____ Date:_____

Leisure activities, including exercise routines:_____

Is your current condition preventing: ❑ leisure activities ❑ exercise ❑ occupational activities

Occupation, including typical workday activities:_____

DOB: _____ Height: _____ Weight:_____
Are you on a work restriction from your doctor? YES NO Are you latex sensitive? YES NO

Do you smoke? YES NO Do you have a pacemaker? YES NO Do you have hearing loss? YES NO

FOR WOMEN: Are you currently pregnant or think you might be pregnant? YES NO

ALLERGIES: List any medication(s) you are allergic to: _____

Have you RECENTLY noted any of the following (check all that apply)?

❑ fatigue	❑ numbness or tingling	❑ muscle weakness
❑ nausea/vomiting	❑ dizziness/lightheadedness	❑ shortness of breath
❑ weight loss/gain	❑ heartburn/indigestion	❑ fainting
❑ difficulty maintaining balance while walking	❑ difficulty swallowing	❑ cough
❑ falls	❑ changes in bowel or bladder function	❑ headaches

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

❑ cancer	❑ depression	❑ thyroid problems
❑ heart problems	❑ lung problems	❑ diabetes
❑ chest pain/angina	❑ tuberculosis	❑ osteoporosis
❑ high blood pressure	❑ asthma	❑ multiple sclerosis
❑ circulation problems	❑ rheumatoid arthritis	❑ epilepsy
❑ blood clots	❑ other arthritic condition	❑ eye problem/infection
❑ stroke/ head injury	❑ bladder/urinary tract infection	❑ ulcers
❑ anemia	❑ kidney problem/infection	❑ liver problems
❑ bone or joint infection	❑ sexually transmitted disease/HIV	❑ hepatitis
❑ chemical dependency (i.e., alcoholism)	❑ pelvic inflammatory disease	❑ pneumonia

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? **YES NO**

Please list all medications you are currently taking: (including dosages and frequency):

* *If you have a list, we will be more than welcome to make a copy for you.*

-Blood Pressure Medication	-Heart Medication	-Anti-coagulants (blood thinners)
_____	_____	_____
-Muscle Relaxants	-Pain Killers	-Diabetes Medication (i.e. insulin)
_____	_____	_____
-Steroids	-Anti-inflammatories	-Other Medications (state condition)
_____	_____	_____

Have you ever taken steroid medications for any medical conditions? **YES NO**

Have you ever taken blood thinning or anticoagulant medications for any medical conditions? **YES NO**

Please List all surgeries you have had (include dates):

_____

_____

_____

CURRENT CONDTION

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

What do you think caused your symptoms? _____

My symptoms are currently: ❑ **Getting Better** ❑ **Getting Worse** ❑ **Staying about the same**

Treatment received so far for this problem (chiropractic, injections, etc) _____

Please list special tests performed for this problem (x-ray, MRI, labs, etc) _____

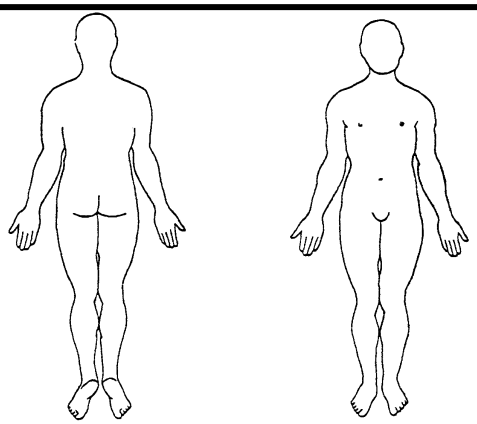
Have you ever had this problem before: ❑ **Yes** ❑ **No** **When**_____ **Treatment rec'd**_____

How long did it take for you to feel better? _____

Body Chart:

Please mark the areas where you feel symptoms on the chart to the right with the following symbols to describe your symptoms:

↓ **Shooting/sharp pain**
O **Dull/aching pain**
||| **Numbness**
= **Tingling**



My symptoms currently: ❑ Come and go ❑ Are Constant ❑ Are constant, but change with activity

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Aggravating Factors: Identify important positions or activities that make your symptoms worse:

_____

Easing Factors: Identify important positions or activities that make your symptoms better:

_____

How are you currently able to sleep at night due to your symptoms?

❑ No problem sleeping ❑ Difficulty falling asleep ❑ Awakened by pain ❑ Sleep only with medication

When are your symptoms worst? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise

When are your symptoms the best? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise

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Using the 0 to 10 the scale, with 0 being *"no pain"* and 10 being the *"worst pain imaginable"* please describe:

Current pain level: _____ Worst pain level within last week: _____ Best pain level within last week: _____

Are you interested in becoming more physically active upon completion of your formal physical therapy treatment? Yes_____ No_____

I certify that the above information is accurate to the best of my knowledge.

_____ _____
(Patient Signature) *(Date)*

_____ _____
(Physical Therapist Signature) *(Date)*