Active Physical Therapy and Sports Medicine

PATIENT DEMOGRAPHICS

LAST NAME:		FIRST NAME:		M.I.:
ADDRESS:		CITY:	STATE:	ZIP:
HOME PHONE:	CELL#:	BIRTHDATE:		SEX: M F
SS#:		MARITAL STATUS: S M W D		
EMPLOYER:		ADDRESS:		
CITY:	STATE:	ZIP:	PHONE:	
IS YOUR AILMENT/INJURY WORK OR CAR ACCIDENT RELATED:			YES	NO

RESPONSIBLE PARTY/GUARANTOR INFORMATION

LAST NAME:		FIRST NAME:		MI:
ADDRESS:		CITY:	STATE:	ZIP:
HOME PHONE:		D.O.B.	SS#	
RELATIONSHIP TO PATIENT:	HUSBAND	WIFE	PARENT	SELF
Date:				

Emergency contact: Phone: Cell Phone:

AUTHORIZATION FOR TREATMENT

I hereby consent to and authorize all therapy treatments, which in conjunction with the judgment of my attending physician, may be considered necessary and/or advisable for the diagnosis and/or treatment of the patients named above at Active Physical Therapy and Sports Medicine.

Signature (Parent or Legal Guardian Must Sign if Under 18):

Relationship to Patient: __Mother __Father __Legal Guardian

I HEREBY ASSIGN ALL MEDICAL BENEFITS TO WHICH I AM ENTITLED TO ACTIVE PHYSICAL THERAPY AND SPORTS MEDICINE IN THE EVENT THEY FILE INSURANCE ON MY BEHALF. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF SAID BENEFITS.

A COPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL. I DO HEREBY CONSENT TO SUCH TREATMENT BY THE AUTHORIZED PERSONEL OF ACTIVE PHYSICAL THERAPY AND SPORTS MEDICINE AS MAY BE DICTATED BY PRUDENT MEDICAL PRACTICE, BY MY ILLNESS, INJURY OR CONDITION. THIS CONSENT IS INTENDED AS A WAIVER OF LIABILITY FOR SUCH TREATMENT EXCEPTING ACTS OF NEGLIGENCE. I CONCENT TO BEING KNOWINGLY PHOTOGRAPHED OR VIDEOTAPED BY AUTHORIZED PERSONEL OF ACTIVE PHYSICAL THERAPY AND SPORTS MEDICINE FOR MEDICAL REASONS SUCH AS POSTURAL CORRECTION, GAIT/MOVEMENT ANALYSIS OR EDUCATIONAL PURPOSES.

Signature: **Today's Date:**

Active Physical Therapy and Sports Medicine

Patient Initial Questionnaire

Name: _____

Date: _____

What is the complaint that brought you therapy? _____

When approximately did this complaint begin? _____

Has it recently worsened? (Please, circle) YES NO

Which of the following best describes how your injury occurred? (Check only one)

__Lifting __Car accident __Running __A fall __Degenerative Process
__Trauma __Athletic Injury __Cumulative trauma/overuse __Unknown __Other

Where did your injury occur? __At Work __Auto __Personal Home __Other Premise __Unsure

Nature of symptoms (check all that apply):

__sharp __throbbing __dull __constant

__aching __occasional __tingling __Other:_____

What makes your pain better? _____

What makes your pain worse? _____

Does your complaint affect your stress level/mood/comfort? (Circle): YES NO

What symptoms are you experiencing with your complaint?

___swelling ___fatigue ___loss of balance or coordination ___stiffness
___tingling ___numbness ___loss of motion ___weakness

What previous treatment have you had for your complaint?

___None ___Medication ___Injections ___ Chiropractor

___Physical Therapy ___Occupational Therapy ___Athletic Training ___ Other

Have you had any of the following?

___X-rays ___MRI ___CT Scan ___Arthrogram ___Bone Scan ___Other

What is your occupation? _____

Are you currently working? __YES __NO __Part-time __Full-time ___Medical leave __Restricted duty

What position are you in while working? ___Standing ___Sitting ___Walking ___Bending ___Lifting lbs _____Frequency_____

Please list any activities that you cannot do because of your complaint: _____

What goal would you like to achieve from therapy?_____

Please check all medical conditions that you have or have had:

___Arthritis	___Heart Disease	___Lung disease	___Depression
___Difficulty sleeping	___Osteoporosis	___High blood pressure	___Stomach disorder
___Diabetes	___Fatigue	___Fibromyalgia	___Pace maker
___Shortness of breath	___Stroke	___Change in appetite	___Panic attack
___Thyroid Disease	___Chest Pain	___Cancer	___Dizziness
___Fever	___Nausea/Vomiting	___Sexually transmitted disease	
___Panic attack	___Unexplained weight gain/loss	___Long term steroid	___Other:

Please check all of the following items that currently or have previously applied to you:

___Hearing problems ___Pregnant ___Bowel/bladder problem

___Visual problems ___Substance abuse ___Learning problems

___I have had a fall in the past 12 months that resulted in an injury.

___I have had 2 or more falls in the past 12 months in which I was not injured.

Please list medications, vitamins/supplements you are currently taking:

Are you currently receiving psychological or social services? ___YES ___NO

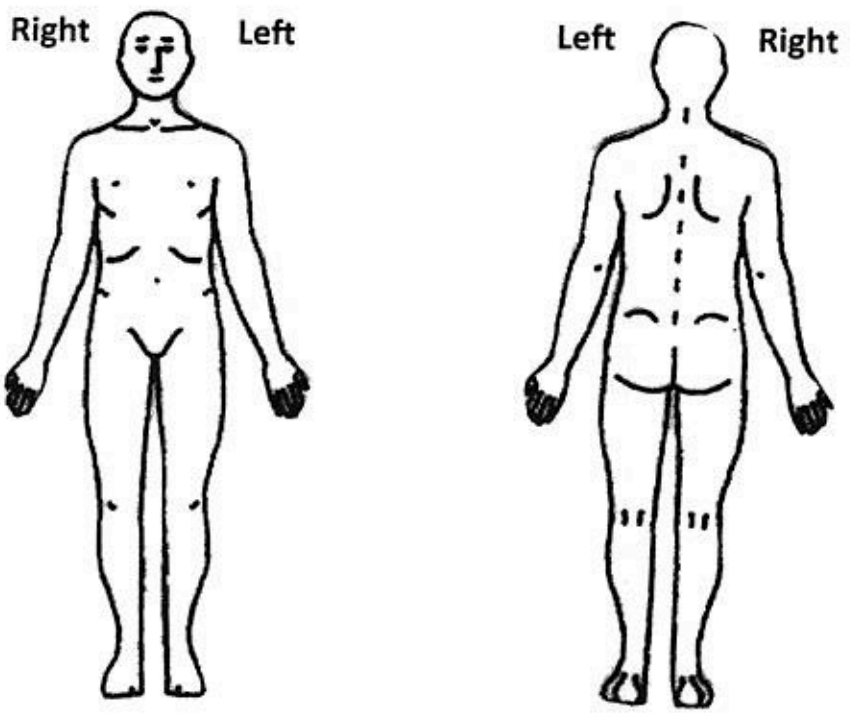
Please circle the number that best describes your pain:

0 1 2 3 4 5 6 7 8 9 10

No pain Worst possible pain

SPATIAL DISTRIBUTION OF PAIN:

Please mark X where you hurt the most



THERAPIST SECTION

How did the patient hear about us? _____

Patient has been made aware of diagnosis and prognosis ___YES ___NO

*Functional score*_____ *Discussed goals with patient* ___YES ___NO

Therapist Signature: _____ Date: _____

Medications:

List medications (including prescribed pills, skin patches, injections, vitamins/supplements and over the counter medicines) you are currently on and their prescribed purpose. Attach list if needed.

Medication Name	Dosage/Frequency	Prescribed Purpose:

Active Physical Therapy and Sports Medicine

No-show and Cancellation Policy

Dear Patient,

Please make every effort to provide at least 24 hour notice if an appointment must be missed. After a repeated record of cancelling/no-showing occurs, patient will no longer be able to schedule appointments ahead of time. In some cases, patients will be discharged if they have a record of too many (3 appointments) cancellations or no-shows. Also, please remember, being 15 minutes or more late for the appointment will lead to shorter session and, in some cases, to cancellation of the session.

We truly value our patients' time as we hope you value ours. Having said that, whenever a patient does not appear for scheduled appointments, everyone is affected – you do not get the treatment that was needed and we lose a spot that another patient could have filled. We understand unexpected conflicts can occur and that your lives are as busy as ours. We strive to work together with you to fit your schedules.

Thank you in advance for your understanding and cooperation.

Agreed to and Acknowledged by:

_____

Patient Name

_____ _____

Patient/Parent Signature Date

ACTIVE PHYSICAL THERAPY & SPORTS MEDICINE

The patient has the right to request information not to be sent to their health plan when paying for a health care item or health care service in full in cash, credit cards and checks. Under the new Rule a patient can now come in and say they are going to pay you cash in full for the health care services they receive during this episode of care and they don't want you to send this information to their health plan. If they do in fact pay for the services in full, we cannot disclose information about the service they received to their health plan (or anyone else for that matter). If they fail to pay for the services in full in cash, then you can bill the health plan without violating the new Rule since you have a right to be paid for the services you provided.

The patient has the right to receive a copy of their health care record in a machine readable electronic format if the record is stored in an electronic format. If you cannot provide a copy of the electronic record in a machine readable format, then you must provide the patient a hard copy of their record.

The time period for complying with a patient's request of a copy of their record is now reduced from 60 days to 30 days with a one-time 30 day extension. You can no longer charge a "search and retrieval" fee for paper copies of the record.

Acknowledgement of Receipt of Notice of Privacy Practices

Active Physical Therapy & Sports Medicine reserves the right to modify the privacy practices outlined in the notice. I have received a copy of the Notice or Privacy Practices for Active Physical Therapy & Sports Medicine.

Name of Patient:_____(please print)

Signature of Patient:_____Date:_____

(parent or legal guardian must sign if patient is under 18)

Relationship to patient _____mother _____father _____legal guardian

Please initial all that apply:

_____Patient agrees to the release of medical or other information to process claim

_____Patient agrees to accept assignment of payment

_____Patient gives the office permission to leave a message on their answering machine or voicemail

_____Patient gives permission to discuss their medical condition with another person, physician or emergency contact

Name_____ Phone#_____ Relationship_____

Documentation of Attempt to Obtain Acknowledgement of Receipt of Notice of Privacy Practice

Attempt to Obtain Acknowledgement

An attempt was made to obtain an acknowledgement of receipt of the Notice of Privacy Practices.

The acknowledgement was not obtained because:

_____The Patient declined to sign the acknowledgment _____Other

_____

Name of Patient (Please print)

_____

Name of Active Physical Therapy and Sports Medicine Employee Date:_____