CHOICE PHYSICAL THERAPY

PHONE: (607) 973-2107 FAX: (607) 654-0105

PATIENT INFORMATION FORM

***First Name*_____ *Last* _____ *MI*_____ *Sex*_____**
What name would you like to be called by?_____
Address_____ City_____ State_____ Zip_____
Primary Phone#(___) ___-_____ Work#(___) ___-_____ Cell#(___) ___-_____
How would you like your appointment reminder? (circle)
Call: Home/Work/Cell OR Text
Date of Birth_____/_____/_____
SS# (Parent # if minor) _____-_____-_____ *Email:* _____
Name of referring Physician _____*Phone#:*_____
Name of Primary Care Physician _____*Phone#:*_____
Emergency Contact: Name:_____ Phone#:_____

INSURANCE INFORMATION

***Primary Insurance*_____ *Policy #*_____**
*Secondary Insurance*_____ *Policy #*_____

Name of person responsible for payment_____
Address_____
Street City State Zip
DOB of Policy Holder_____ Date of injury_____
Employer_____ Relationship to patient_____

(Circle) WORKERS COMPENSATION OR MOTOR VEHICLE ACCIDENT INFORMATION

Name of employer (at time of injury) OR Auto Insurance Company

_____
Address_____
WC Insurance carrier of employer/Name of Policy Holder

_____
Address_____
Phone # of insurance company (_____) _____-_____ Fax # (_____) _____-_____
Date of Injury _____/_____/_____ CC#_____
Policy # and/or File #_____
Name of Case Manager? _____

SOCIAL SECURITY DISABILITY

Are you receiving Social Security Disability? (circle) YES NO

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**** * * COPAYMENTS ARE DUE AT THE TIME OF SERVICE * * ****

Financial Agreement

Please ask any questions you may have before signing below:

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I am aware that Choice Physical Therapy reserves the right to bill me for $25 sessions missed with less than 24 hours notice. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I understand that my insurance may only cover certain types or lengths of treatment, a typical course of therapy is at least 4-6 weeks. I am also aware that my insurance may not cover therapy if my primary doctor does not approve. I accept full responsibility for all charges not covered by insurance.

X Signature_____Date_____/_____/_____

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MEDICAL HISTORY FORM

Date_____/_____/_____

Name_____ DOB ____/____/_____

How did you hear about us? _____

What brings you here today? _____

Date of surgery or onset of illness that brings you here today_____/_____/_____

Please rate your current pain on a scale of 0-10 (0=no pain, 10=worst pain) _____

Do you have, or have you had, any of the following:

□ Osteoarthritis/DJD	□ Drug or alcohol dependency	□ Tobacco use
□ Rheumatoid Arthritis	□ Low blood sugar/hyperglycemia	□ Pacemaker
□ Asthma	□ Head Injury	□ HIV/AIDS
□ Broken bones/fractures	□ Multiple Sclerosis	□ Kidney problems
□ Osteoporosis	□ Muscular Dystrophy	□ Ulcers/Stomach problems
□ Blood disorders	□ Parkinson's Disease	□ Skin diseases
□ Circulation/vascular problems	□ Seizures/epilepsy	□ Depression/Anxiety
□ Heart problems	□Disorders of eyes/ears/sinus	□ Current Pregnancy
□ High blood pressure	□ Developmental/growth problems	□ Headaches/migraines
□ Lung problems (COPD/CHF)	□ Thyroid Problems	□ Use of antibiotic/steroid
□ Stroke	□ Cancer_____	anti-inflammatory medications
□ Diabetes/high blood sugar	□ Infectious Disease (tuberculosis, hepatitis)	
□ Anemia	□ Lymph/lymph node problems	

□ Other_____

□ ***Allergies*** _____

Past surgical history: _____

Are you currently taking any medications (prescriptions/over the counter)? **Y N** Please list:

_____

Are you here for rehabilitation to return to your previous or a different employment? **Y N**

Have you received speech/physical therapy at home or another facility during this calendar year? _____

If answer is yes to the following two questions, please provide a copy or let us make a copy for you.

Do you have a healthcare proxy? **Y N** Who is your proxy? _____Phone:_____

Do you have a "Do Not Resuscitate Order" (DNR) or other Advance Directives in place? **Y N**

Have you been a patient in a hospital or clinic within the past five (5) years? **Y N**

If yes, where/date/reason: _____

Have you had any diagnostic tests (x-rays, blood, cardiogram, etc.)? **Y N**

If yes, where/date/reason:_____

Is there any other pertinent information not addressed above? **Y N**

If yes, where/date/reason: _____

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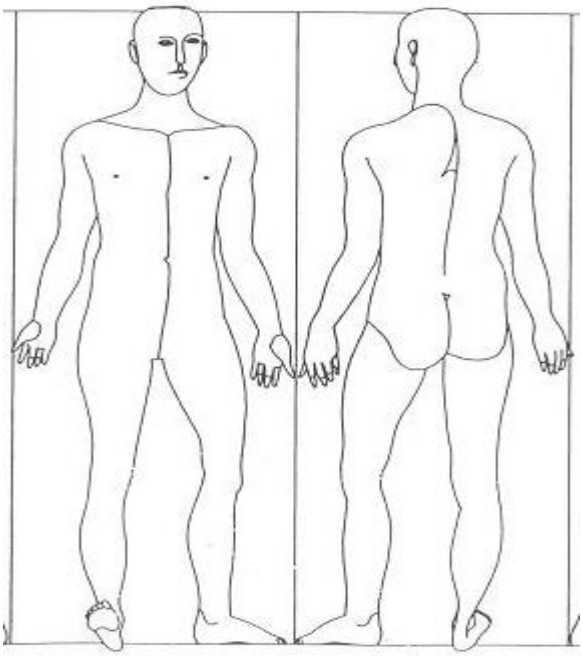

On the diagram to the left:

Place an X over areas of pain
Place //// over areas of numbness/tingling

*Therapist Notes: ___/___/___

X Signature_____Date_____/_____/_____

Authorization for Release of Medical Information

I authorize Choice Physical Therapy to obtain information from: (i.e. surgeon/doctor)

Name of Provider/Facility: _____

For the purposes of: Care Continuity, Insurance Coverage and, Relevant background Information
Other Notes:_____

I understand that:
(1.) My right to healthcare treatment is not conditioned on this authorization. (2.) I may cancel this authorization at any time by submitting a written request to the address at the bottom of this form, except where a disclosure has already been made in reliance on my prior authorization. (3.) If the person or facility receiving this information is not a healthcare or medical insurance provider covered by privacy regulations, the information stated above could be re-disclosed. (4.) Release of HIV related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization. (5.) There may be a charge for the requested records. (6.) Photocopies or facsimiles of this document are valid.

I agree to maintain confidentiality of all information obtained in the course of my treatment including, but not limited to, financial, technical, or propriety information of the organization and personal and sensitive information regarding other patients, employees, and vendors. I further understand that information regarding my care will never be shared by any representative of Choice Physical Therapy unless written permission is obtained.

Signature of patient or representative: _____ Date: _____

Relationship to patient (If requester is not the patient):_____