PT Plus Intake/Registration Form

Patient's Name: ______________________________________Date of Birth:___________________

Address: ____

City: _____________________________ State:_________________ Zip:______________

Telephone Numbers: (H) _________________ (W) _________________ (C)______________

Email Address:____

Emergency Contact:________________________________Telephone:____________________

Referring Physician: ______________________ Primary Physician: ______________________

Nature of Patient's Problem: ____

Date the Patient/ Physician's Office Called: ____________ Date Seen by MD: ______________

Date Patient Scheduled for PT Evaluation: _______________ PT: ________________________

Complete the following sections for all new patients:

Health Insurance Company: _______________________________________ Phone: _______________

Policy Holder's Name: __________________________________

Policy Holder's DOB: ________________________ Policy #: _______________________

Group #: ____________________________

Ailment Information

Is your ailment: ____ work related ____ auto accident ____ neither ____ other

If work related, has your employer filed a workers' comp claim with its insurance? _______

Case Manager: _____________________________ Telephone #:________________

Claim # :______________________________ Date of Injury:_____________________

Workers Comp Insurance: ____

How did you hear about PT Plus?

___ I was a previous patient ___ physician ___ physician office
___ employer ___ friend (friend's name______________)
___ yellow pages ___ other ___________________________

Medical History Questionnaire

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

NAME: ________________________________TODAY'S DATE: _________________

OCCUPATION:____

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

Are you latex sensitive? ❑ Yes ❑ No

List any allergies we should know about: ___________________________________

Please check any of the following whose care you are under currently:

❑ Medical Doctor ❑ Psychologist/Psychiatrist ❑ Other: _____________
❑ Osteopath ❑ Physical Therapist ___________________
❑ Dentist ❑ Chiropractor ___________________

If you have seen any of the above in the last 4 months, please describe for what reason(s):
____

PAST MEDICAL HISTORY:

Have you *ever* been diagnosed as having any of the following conditions?:

____Yes ____No Cancer (If yes, please describe ______________________)
____Yes ____No Heart Problems
____Yes ____No Circulation Problems
____Yes ____No Infection (staph, strep, C-diff, etc.)
____Yes ____No High blood pressure
____Yes ____No High cholesterol
____Yes ____No Angina or chest pain
____Yes ____No Asthma
____Yes ____No Emphysema / Bronchitis
____Yes ____No Tuberculosis / Other Lung Disease
____Yes ____No Kidney Disease
____Yes ___ No Thyroid Problems
____Yes ____No Diabetes
____Yes ____No Arthritis (Rheumatoid, Osteo-, or other arthritic conditions)
____Yes ____No Chemical Dependency / Addiction (i.e., alcoholism)
____Yes ____No Multiple Sclerosis
____Yes ____No Epilepsy
____Yes ____No Depression
____Yes ____No Hepatitis
____Yes ____No Stroke
____Yes ____No Anemia
____Yes ____No Other: _______________________________________

If you checked "Yes" for any of the above, please explain:

____

____

____

____

During the past month, have you been feeling down, depressed or hopeless? ❑ Yes ❑ No

During the past month, have you been bothered by having little interest or pleasure in doing things? ❑ Yes ❑ No

Do you ever feel unsafe at home, or has anyone hit you or tried to injure you in any way?
❑ Yes ❑ No

FOR WOMEN: Are you currently pregnant or think you might be pregnant? ❑ Yes ❑ No

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
1.	__________	____
2.	__________	____
3.	__________	____
4.	__________	____
5.	__________	____

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

	DATE	INJURY
1.	__________	____
2.	__________	____
3.	__________	____

Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the following? (Circle those that apply.)

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

Which of the following OVER-THE-COUNTER medications have you taken in the last week?
❑ Yes ❑ No Aspirin
❑ Yes ❑ No Tylenol
❑ Yes ❑ No Advil / Motrin / Ibuprofen
❑ Yes ❑ No Laxatives
❑ Yes ❑ No Decongestants
❑ Yes ❑ No Antihistamines
❑ Yes ❑ No Antacid
❑ Yes ❑ No Vitamins / Mineral Supplements
❑ Yes ❑ No Other: ____

Please list any PRESCRIPTION medication, with dosages, you are currently taking (INCLUDING pills, injections, and/or skin patches): you may attach a separate list

	MEDICATION	DOSAGE
1.	___________________________	___________________
2.	___________________________	___________________
3.	___________________________	___________________
4.	___________________________	___________________
5.	___________________________	___________________
6.	___________________________	___________________

How many caffeinated beverages (coffee or other 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 = one beer or glass of wine, how many do you drink in an average sitting? ________

Have you recently noted the following:

❑ Yes ❑ No Weight Loss or Gain
❑ Yes ❑ No Nausea / Vomiting
❑ Yes ❑ No Dizziness / Light Headedness
❑ Yes ❑ No Fatigue
❑ Yes ❑ No Weakness
❑ Yes ❑ No Fever / Chills / Sweats
❑ Yes ❑ No Numbness or Tingling

Do you have any medical problems that would limit your ability to exercise? ___Yes ___No
If yes, please explain:

____

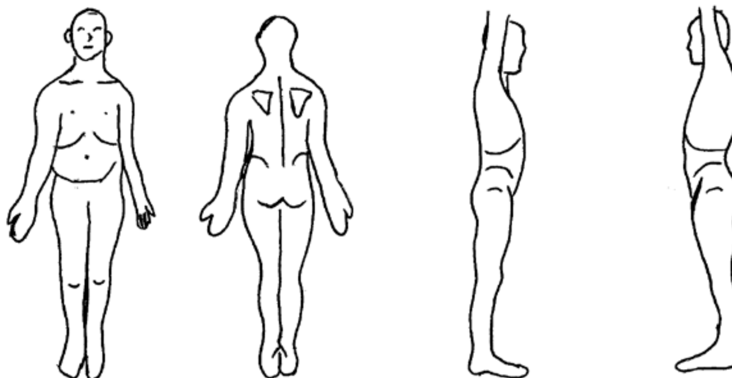
____

________________________________   ____

Patient's Signature Date Physical Therapist's Signature Date

PATIENT HISTORY

Name______________________________ Date__________________



1. Where are your symptoms located? (Darken areas on body diagrams above.)
2. When did your symptoms begin? ______________________________
3. Are your symptoms related to:
   ❑ Accident ❑ Trauma ❑ Gradual Onset ❑ Work-Related Injury describe:
   ____
4. What makes you feel better? ____
5. What makes you feel worse? ____
6. Circle the words that best describe your symptoms:
   Sharp Ache Burning Tingling Stabbing Throbbing
7. What Level is your Pain, on a scale of 0 to 10, with 0 being None, and 10 the worst pain imaginable? _________________________
8. Even if unrelated to the current ailment, have you (check the one that best applies):
   - ❑ I have had 0 falls in the past 1 year
   - ❑ I have had 1 fall in the past 1 year, without injury
   - ❑ I have had 1 fall in the past 1 year, with injury
   - ❑ I have had 2 or more falls in the past 1 year
9. Have you been seen for this ailment by another healthcare practitioner within the past 4 months? ❑ No ❑ Yes Who? ___________ Treatment: ________________
10. Please list any relevant diagnostic tests: ___________________________________
11. Employed Status: ❑ Full Time ❑ Part Time ❑ Out of Work ❑ Light Duty ❑ Retired

INFORMED CONSENT

I consent to receiving physical therapy services which are deemed medically necessary by my referring and/or primary care physician. I authorize the release of medical information to my referring physician and insurance company. I hereby assign all medical benefits to be paid directly to PT Plus.

I understand that it is my responsibility to obtain pre-authorization for physical therapy if it is required by my insurance company.

I also understand that PT Plus requires payment at the time of service for office visits. I am aware PT Plus will submit charges for services to my insurance company unless I make other arrangements. In consideration for this convenience, I am also aware that PT Plus expects payment of my balance within 7 – 10 days after receiving a statement.

I realize I am responsible for all charges incurred, regardless of payment by my insurance company, with the exception of any HMO's for which PT Plus has signed a contract as a participating provider. Any charges not paid by my insurance company, if other than an HMO PT Plus participates with, will become my responsibility within 60 days.

I assign any proceeds from any cause of action, whether from a court award or settlement, in the hands of my attorney, the responsible party, or the insurance carrier for the responsible party to PT Plus. I authorize and direct my attorney to pay all outstanding bills to PT Plus from the proceeds of any settlement. A monthly finance charge of 1 % of the outstanding balance, with a minimum of fifty cents ($ .50), will be applied to my balance after thirty (30) days. If it becomes necessary for my account to be assigned to a collection agency, I agree to pay all collection costs and attorney fees. This will include legal fees at the rate of 25 % of the outstanding balance. I understand that there is a twenty dollar ($ 20.00) handling fee for "no shows" and cancellations of appointments without providing twenty-four (24) hour notice.

______________________________	____________________
Patient Signature	Date
______________________________	____________________
Parent or Legal Guardian	Social Security Number

Under The Health Insurance Portability and Accountability Act of 1996 (HIPAA), health care providers are required to follow certain rules of privacy that may affect out patients' personal health information.

Uses and Disclosures

PT Plus may use your personal health information about you and health information about your ailment or condition in communication with your healthcare team. Your physical therapist may share information with you verbally and/or in writing with your physician(s) in order to carry out your plan of care. If you would like to pursue insurance reimbursement for our services, insurance companies often require private health information in order to process the claims we may print for you to submit to them for your reimbursement.

Individual Rights

Under HIPAA, every individual receiving care has the right to privacy of personal health information. These rights apply to verbal communication, as well as written information. You have the right to your medical records, after signing an authorization form.

Our Responsibilities

The staff at PT Plus understands your rights and is sensitive to the importance of the privacy rules. It is our duty to do the following:

- Handle only the minimum personal health information necessary and required by insurance carriers for printing claims for your reimbursement.
- Use discretion when discussing your ailment and treatment with you, members of your therapy team, your physician, by phone or in person (will move to a more private room and lower our voices)
- Use discretion when sending written information to your physician either by mail or by fax
- Refrain from using e-mail to transmit any of your health information
- Not share your personal health information with any unauthorized entities
- Keep charts in secure areas at all times
- Maintain confidentiality

Complaints

If you feel your privacy rights have been violated, you may contact Laura Coleman, PT, ATC, at (434) 823-7628 to report your complaint. As the owner, I want to know about any problems within our organization so that we can remedy them as quickly as possible. I will respect confidentiality of all complaints.

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of PT Plus' **Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

____

____

____

Further, I permit a copy of this authorization to be used in place of the original.

Signed:____________________________________ Date:__________________________

Name: ____________________________________

(please print)

If not signed by patient, please indicate relationship to patient (e.g., spouse)

Relationship: __________________ Witnesses by: ________________________

Please bring this signed form with you to your first session with the Physical Therapist.

Thank you !

Internal Use Only:

If patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to patient and sign below.

Presented on (date and time):____________________________________

By: (name and title): ____