

PHYSICAL THERAPY & SPORTS INJURY REHABILITATION
PATIENT INFORMATION

PLEASE PRINT

Name: _____ Date of Birth: _____ Age: _____
Address: _____ Social Security# (last 4 digits): _____
City: _____ State: _____ Zip Code: _____ Sex: M / F
Home#: _____ Cell#: _____ Work #: _____
Email address: _____
Emergency Contact Name: _____ Relation: _____ Phone: _____

PATIENT EMPLOYER INFORMATION

Employer: _____ Job Title: _____
Address: _____ City: _____ State: _____ Zip Code: _____

POLICY HOLDER INFORMATION

If you are **NOT** the policy holder listed on your insurance card, **PLEASE** complete the following:

Relationship to the Insured: Circle One Family Spouse Employee Other

Insured's Name: _____ Birth Date of Insured: _____

Address: _____ City: _____ State: _____ Zip Code: _____

HOW DID YOU HEAR ABOUT PTSIR?

- | | | |
|------------------------------------------------------------|--------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Physician | <input type="checkbox"/> Insurance Company | <input type="checkbox"/> Facebook/Social Media |
| <input type="checkbox"/> Website | <input type="checkbox"/> Friend | <input type="checkbox"/> Previous Patient |
| <input type="checkbox"/> Advertisement; Please List: _____ | | <input type="checkbox"/> Other: _____ |

INJURY INFORMATION

Date of Onset / Injury / Surgery: _____ State where injury took place: _____

Is this injury related to ? Work Car Accident Other Liability/Potential Lawsuit Not Applicable

Please read and Sign the following:

I hereby authorize release of any information, including reports of diagnosis, treatment prognosis, recommendation, benefits payable, as well as any other data pertinent to my treatment, to the physician who referred me for therapy, and/or to any organization responsible for the payment of my account. I acknowledge and understand that I am responsible for all of the charges for services rendered to me by Physical Therapy & Sports Injury Rehabilitation. Although I request that services be billed to the responsible organization on my behalf, I clearly understand that it is still my responsibility to make sure the bill is paid in a reasonable time. If for any reason, any portion of my bill is not paid by the responsible organization, I further agree to make arrangements for prompt payment of the bill. I hereby authorize the responsible organization to pay the proceeds of any benefits due to me directly to Physical Therapy & Sports Injury Rehabilitation. A copy of this can be considered as an original for insurance purposes and valid as an original. I hereby consent to such treatment procedures and patient care which in the judgment of my therapist, or physician, may be considered necessary or advisable while a patient at Physical Therapy & Sports Injury Rehabilitation.

If you are unable to keep an appointment, we require that you provide PTSIR with a 24 hour notice. PTSIR has a \$25.00 fee for all appointments canceled with less than a 24 hour notice or a no show. Insurance companies do not pay for this charge. Therefore you will be the party responsible for payment of the \$25.00 cancellation fee. Your signature acknowledges and agrees to this cancellation policy.

Date: _____ Signature: _____

PTSIR

PATIENT HISTORY QUESTIONNAIRE

PHYSICAL THERAPY AND SPORTS INJURY REHABILITATION

PERSONAL INFORMATION

I am currently: Employed Employed with restrictions On medical leave Not Employed

Interests/hobbies are: _____

Best way to reach me: Phone Email Address _____

Is there anyone who can assist you with doing home exercises or activities if needed? Yes No

Will you have any problems attending therapy sessions? No Yes, If yes, please describe _____

Next scheduled Dr. appointment: Date: _____ Physician: _____

What is your MAIN complaint? _____

Please describe when and how your symptoms began: _____

GENERAL HEALTH

1. Activity Level: Low Medium High

2. Prior to your injury or illness, what activities could you do that you are unable to do now? _____

3. Are you aware of your diagnosis? Yes No 4. Are you aware of your prognosis? Yes No

5. Have you fallen in the last year? Yes No

6. CHECK ALL THAT APPLY:

<input type="checkbox"/>	Chronic Back Pain
<input type="checkbox"/>	Cancer <input type="checkbox"/> In Remission
<input type="checkbox"/>	Stomach Disorders
<input type="checkbox"/>	Contagious Disease
<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	Tingling or Numbness

<input type="checkbox"/>	Visual Problems
<input type="checkbox"/>	Kidney Disease
<input type="checkbox"/>	Mental Illness
<input type="checkbox"/>	Fainting Spells
<input type="checkbox"/>	Heart Disease
<input type="checkbox"/>	Hearing Problems

<input type="checkbox"/>	Back Injury
<input type="checkbox"/>	Skin Disease
<input type="checkbox"/>	Lung Disease
<input type="checkbox"/>	Parkinson's
<input type="checkbox"/>	Pacemaker
<input type="checkbox"/>	Osteoporosis

<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	Allergies
<input type="checkbox"/>	Asthma
<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	Stroke
<input type="checkbox"/>	Anxiety

<input type="checkbox"/>	Fracture
<input type="checkbox"/>	Hernia
<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	Gout
<input type="checkbox"/>	Head Injury

I CURRENTLY DO NOT HAVE ANY OF THE ABOVE CONDITIONS.

7. Do you have uncontrolled leakage of urine? Yes No 8. Do you have loss of bowel control? Yes No

9. Do you smoke? Yes No 10. Do you drink alcohol? Yes No

11. Are you on a special diet? Yes No 12. Any chance you are pregnant? Yes No

13. Please list current medications with dosages and their associated condition. Check if you have attached a list.

_____ / _____	_____ / _____
_____ / _____	_____ / _____
_____ / _____	_____ / _____

14. Please list any prior surgeries or hospitalizations.

15. For patients 12 years or younger, is immunization/vaccination status current? Yes No

PERSONAL GOALS FOR THERAPY

16. What do you WANT to achieve from having therapy? Check all that apply:

- Improve home activities
- Improve mobility/walking activities
- Improve leisure/sports activities
- Decrease or eliminate pain/discomfort
- Improve self-care activities
- Return to work: Current job Other job

17. Please include any additional information you feel would help us provide your care (ie. What you think would help; any apprehension about treatment; spiritual or cultural needs). _____

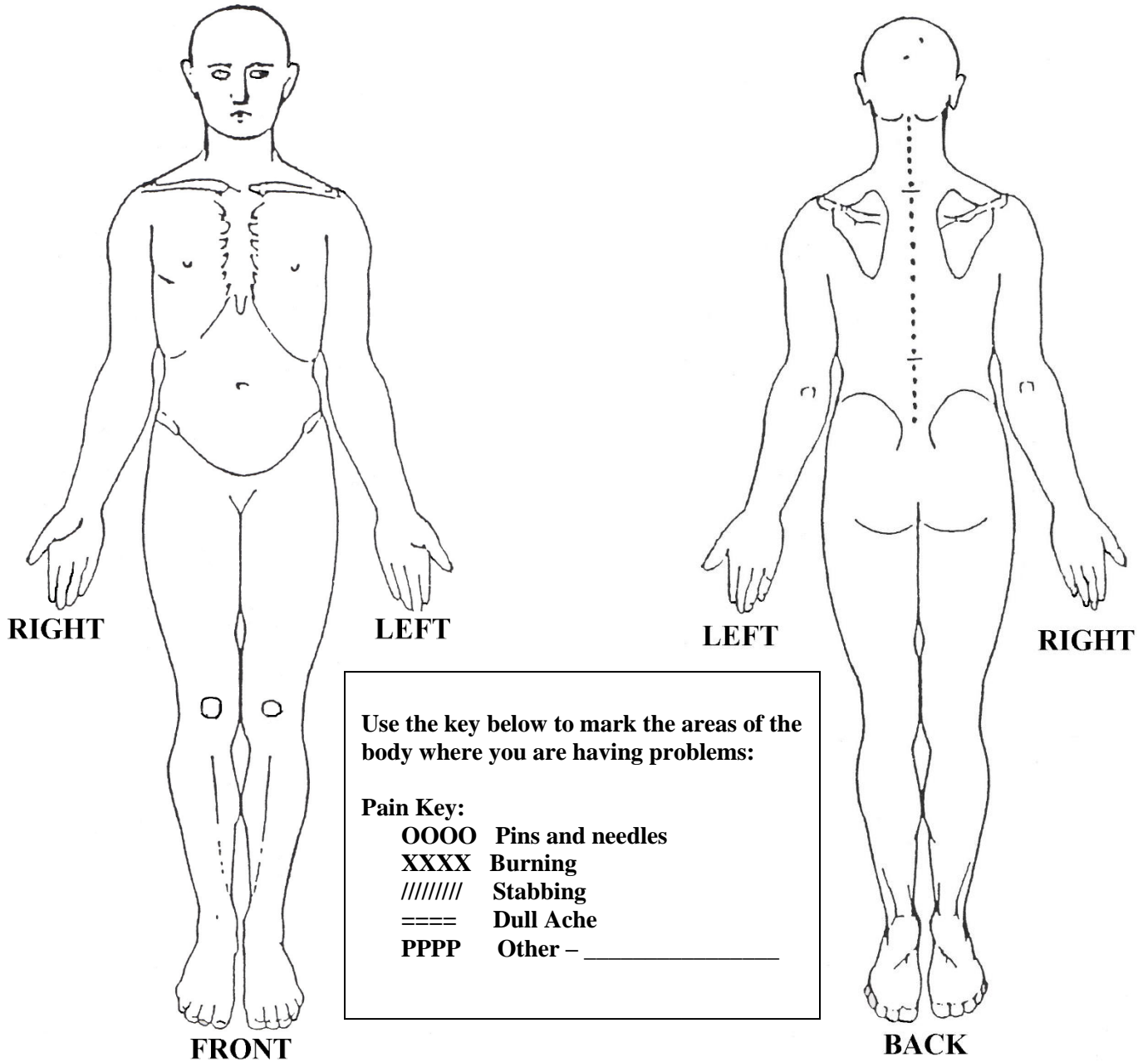
18. Please rate your pain level at rest: NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN

19. Please rate your pain with activity: NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN

20. Is your pain (Please check all that apply): Increasing Decreasing Staying the same Occasional Constant

21. What increase your pain? _____

22. What decrease your pain? _____



To the best of my knowledge, the above information is complete and factual.

Patient Signature

Date

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Physical Therapy and Sports Injury Rehabilitation (**PTSIR**) for the purpose of evaluating or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of **PTSIR**. I understand that evaluation or treatment of me by **PTSIR** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. **PTSIR** is not required to agree to the restrictions that I may request. However, if **PTSIR** agrees to a restriction that I request, the restriction is binding on **PTSIR**.

I have the right to revoke this consent, in writing, at any time, except to the extent that **PTSIR** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition, and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review **PTSIR**'s Notice of Privacy Practices prior to signing this document. **PTSIR**'s Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of **PTSIR**. The Notice of Privacy Practices for **PTSIR** is also provided at the receptionist desk. This Notice of Privacy Practices also describes my rights and **PTSIR**'s duties with respect to my protected health information.

PTSIR reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the **PTSIR** office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Name of Patient or Personal Representative

Date

Description of Personal Representative's Authority

MEDICARE START OF CARE NOTICE

PHYSICAL THERAPY

Name _____ Medicare # _____
(Last) (First)

Birthdate _____ Sex _____ Date Therapy Started _____

Address _____

City _____ State _____ Zip Code _____

Diagnosis _____ Date of Onset _____

STATEMENT TO PERMIT PAYMENT FOR REHABILITATION SERVICES TO PHYSICAL THERAPY AND SPORTS INJURY REHABILITATION, LTD.

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made on my behalf. (The statement above authorizes payment by Medicare directly to Physical Therapy and Sports Injury Rehabilitation, Ltd.)

Signature _____ Date _____

Witness (When applicable) _____

After you pay your yearly Medicare Part B deductible, Medicare pays its share (80%) and you pay your share (20%) of the cost. If you have secondary insurance coverage, most insurance companies automatically cross over from Medicare. If Medicare does not send your 20% to your secondary insurance, we would be happy to help you in filling out these forms. There is a \$2,080 per year limit with an exception process for outpatient physical therapy and speech therapy combined starting January 1, 2020. Effective January 1, 2020, if you receive physical therapy services or speech therapy services in a private practice, a physician's office, a skilled nursing facility, rehabilitation facility, or hospital outpatient physical therapy department, the \$ 2,080 with an exception process will apply to you.

I have read and received a copy of this form.

Signature _____ Date _____

Witness (When applicable) _____

Have you received Home Health Care including physical therapy or nursing in the past 90 days?

Yes No If yes, please complete the following:

Home Health Agency Name _____ Phone _____

If your injury or illness is work related, due to an auto accident or accident on property other than your own, Medicare regulations require PTSIR to file with your liability insurance or workers compensation first.