PATIENT INFORMATION FORM

PLEASE PRINT AND COMPLETE ALL ENTRIES

Patient Name ____ Marital Status _____________

Street Address____ Email Address:________________

Mailing Address _______________________________________ Home Phone __________________

City __________________________ State ________ Zip ________ Cell Phone __________________

Social Security # __________- _________- ___________ Date of Birth _____/_____/______

Employer ____ Occupation _____________________

Address ____ Work Phone ______________________

City ___________________________ State ___________ Zip __________

Accident Related? __________ Nature of Accident ____

Date of Injury ______/______/______ Nature of Problem ____

Referring Physician _________________________

Have you been to Frenchtown Physical Therapy before? Yes No

→ EMERGENCY CONTACT_____________________**Relationship**____________**Phone**____________

INSURANCE INFORMATION

Person Responsible for Bill______________________________________ Date of Birth_____/_____/_____

Address (if different)____Home Phone No.______________

Occupation____________________Employer____

Employer Address____Employer Phone No.______________

ACCOUNT TYPE (circle): Health Insurance Medicare Medicaid (Passport Provider Name)______________

Private Pay Auto Insurance Workman's Comp Veteran's Administration Other:______________

Insurance Company ______________________________________ Phone _________________________

Address ___________________________________ City _______________________ Zip ___________

Policy Holder Name ___________________________ Date of Birth _______/ ______/ _______

Insured's ID # _______________________________ Group/Claim # ______________________________

Co-Pay Amount_______________ Has your deductible been met for the year? Yes No

(continue next page)

Secondary Insurance (if applicable)_________________________________Phone_______________________________

Policy Holder Name____________________________Policy #____________________Group #____________________

Policy Holder ID #_____________________________

PAYMENT IS DUE AT TIME OF SERVICE. Co-payments are expected at time of service in accordance with your health insurance policy and benefits. <u>There will be a 1.25% per month (15% APR) charge on any unpaid balance.</u>

AUTHORIZATION: I authorize the release of any information acquired in the course of my treatment to my treatment to my insurance carrier and physician. I authorize payment of medical benefits directly to Frenchtown Physical Therapy for services rendered. I accept responsibility for payment of services not covered by my insurance.

→ Signature ____________________________________ Date _____________________________________

HIPPA NOTICE: This information will only be used for communication with you, your physician, and your insurance company

GENERAL MEDICAL HISTORY

Name: ____ Date:____________

Dominant hand: [Check one] Right handed _____ Left handed_____

Tobacco/Nicotine (smoking, chew, etc.)None___ Light___ Medium___ Heavy___

Alcohol: How many drinks do you have each week? ________

Caffeine: How many caffeinated beverages do you consume each day?______

Exercise: How many times do you exercise each week?______

PAST MEDICAL: Do you have, or are you at high risk for: [X appropriate box; Add comments below.]

#*	**Disease**	**Yes**		#*	**Disease**	**Yes**
1.	Cancer of any type			14	Polio	
2.	Diabetes			15	Chronic bronchitis	
3.	Hypoglycemia, low blood sugar,			16	Pneumonia (Case in the last 6 months)	
4.	High blood pressure			17	Emphysema, or other lung disease	
5.	Heart disease, chest pain, angina,			18	Migraine headaches	
6.	Shortness of breath			19	Anemia, or other blood disorders	
7.	Stroke			20	Ulcers or stomach problems	
8.	Kidney disease/stone			21	Depression, mental health concerns	
9.	Urinary tract infection.			22	Chemical dependency	
10	Asthma, hayfever			23	Arthritis or gout	
11	Rheumatic/scarlet fever			24	Epilepsy	
12	Hepatitis or liver disease			25	Thyroid problems	
13	Osteoporosis or osteopenia			26	Allergies	

* Comments [Example: # 1, skin cancer.], or other health concerns:

____.

____.

MEDICATIONS & purpose: [Ex., Aspirin – heart.] ______________________________________.

____ _________.

MAJOR SURGERIES: ____.

____ _____.

PERSONAL GOALS FOR PHYSICAL THERAPY: ________________________________ ____.

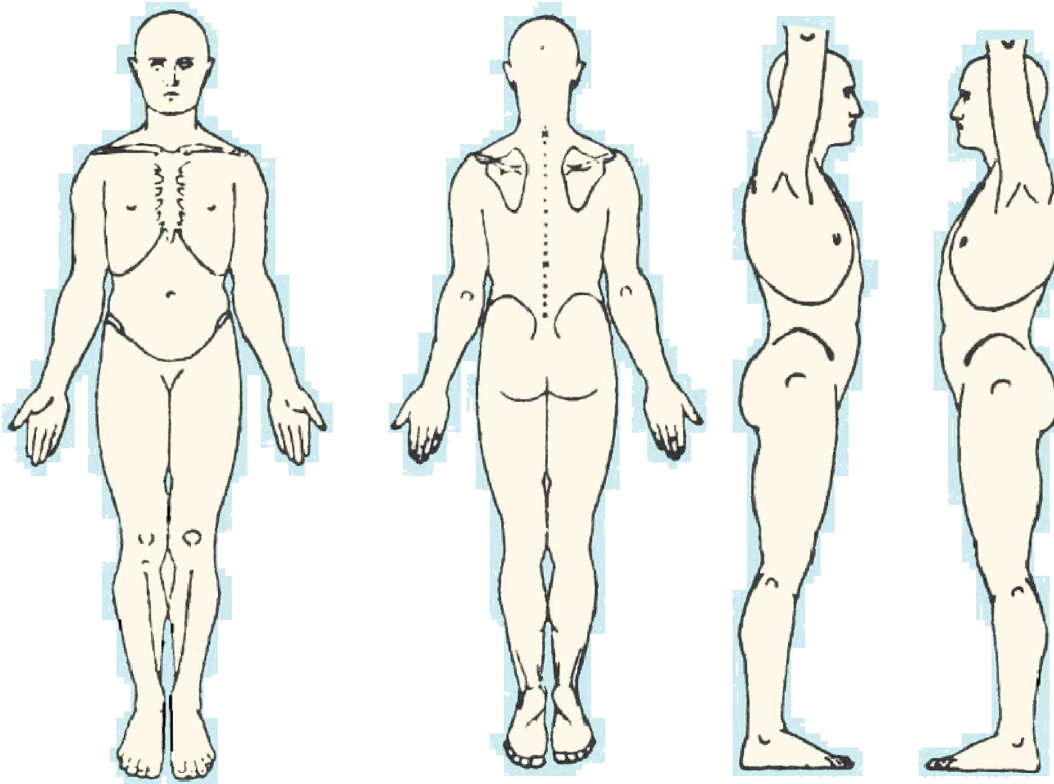
____ _____.

How big of a lifestyle change are you willing to make to reach your PT goals? Major______

Moderate_____ Minor_____ None____

PLEASE DRAW YOUR SYMPTOMS ON THE BODY CHART

Name:______________________________________ **Date:**_______________



AREA # 1: __________________ Highest pain in 24 hours (10 worst, 0 none) ____

CIRCLE ALL WORDS THAT DESCRIBE YOUR PAIN:

1. Sharp	2. Shooting	3. Burning	4. Dull
5. Throbbing	6. Ache	7. Tingling	8. Numb
9. Heavy	10. Tight	11. Pulling	12. Stabbing

CIRCLE ALL WORDS THAT DESCRIBE THE **BEHAVIOR** OF YOUR PAIN:

(A) Constant, never goes away
(B) Intermittent, relieved with some positions or rest
(C) Occassional, daily or less often
(D) Infrequent, once a week or once a month.
(E) Previously, no longer present.
(F) Variable, sometimes worse than other times.

_ _

AREA # 2: __________________ Highest pain in 24 hours (10 worst, 0 none) ____

CIRCLE ALL WORDS THAT DESCRIBE YOUR PAIN:

1. Sharp	2. Shooting	3. Burning	4. Dull
5. Throbbing	6. Ache	7. Tingling	8. Numb
9. Heavy	10. Tight	11. Pulling	12. Stabbing

CIRCLE ALL WORDS THAT DESCRIBE THE **BEHAVIOR** OF YOUR PAIN:

(A) Constant, never goes away
(B) Intermittent, relieved with some positions or rest
(C) Occassional, daily or less often
(D) Infrequent, once a week or once a month.
(E) Previously, no longer present.
(F) Variable, sometimes worse than other times.

TO OUR PATIENTS REGARDING
CANCELLATIONS AND NO-SHOWS

The following are our policies regarding cancellations and no-shows. We take this subject very seriously at Frenchtown Physical therapy because it can make a difference between whether you succeed in your treatment or not. Usually your referring doctor has prescribed a set frequency of treatments.

► We require 24 hours notice in the event of a cancellation. It is your responsibility, when you call in, to have an alternative time in mind that will ensure you get the full-prescribed number of treatments that week.
► There is a $15 charge for a cancellation without proper notice. This charge will not be covered by insurance, but will have to be paid by you personally prior to your next treatment.
► For Worker's Compensation and motor vehicle accident patients we are required to document any missed appointments. All notes are forwarded to your case manager and primary physician and this could jeopardize your claim.
► If you feel it is time to decrease the frequency of visits, please discuss this with your therapist at your next appointment.

When you don't show as scheduled, three people are affected: (1) You – because you don't get treated on a regular basis (prolonging recovery); (2) The therapist who now has an empty space in their schedule since the time was reserved for you personally; (3) Another patient who could have been scheduled for treatment if you had given proper notice.

Please cooperate with us in this regard. We are looking forward to working with you.

____________________________________ ____________________
Patient signature Date

INFORMATION FOR NEW CLIENTS

OFFICE HOURS
Appointments are available from 8:00am to 5:00pm Monday thru Friday. Appointments may be available at other times with advanced notice.

DOCTOR'S APPOINTMENTS
We write the doctor a letter to tell him/her about your progress, and frequency of treatment. Please tell us three days in advance (and remind us!) when you are going to see your doctor so that we can write them.

APPOINTMENTS
Please make appointment two weeks in advance, so that we can accommodate your schedule. Be sure your appointment is on the calendar - don't assume it will be the same time next week.

If you prefer to work with a particular therapist, let the front office person know. A therapist schedule is located at the front desk.

"Prime Time" is 3:00-5:00pm. A lot of people want to come after school or work. If your schedule allows you to schedule at another time, please do so. "Prime Time" is also the time you are most likely to wait for service.

<u>If you must change or cancel an appointment, please call at least 24 hours in advance to avoid a $15.00 "No Show" fee.</u>

YOU MUST PAY CASH FOR SUPPLIES
If you purchase tape, cold packs, braces, or other supplies, you must pay cash when you receive them. We are glad to write your insurance company to assist with reimbursement.

HAS YOUR HEALTH CHANGED?
If you are pregnant (or might become), alert your therapist immediately, as it changes the treatment we use. If you get new medications that affect your heat rate, blood pressure, or response to exercise, please let us know.

CONFIDENTIALITY
Your medical information is confidential. Consequently, please do not ask us how your friend is doing in physical therapy – ask your friend!

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

We understand that medical information about you and your health is personal. We are committed to protecting this information. We keep a medical file to improve the quality of your care, and for certain legal requirements.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU:

1. For Treatment: People in our office and from your doctor's office may have access to your file. This may include physical therapy students.
2. For Payment. Many insurance companies require medical information in order to process your claims. We may visit with your case manager/claims examiners unless you specifically ask us to do otherwise.
3. If requested by family/guardians. We will share information with family members and guardians unless you specifically ask us to do otherwise.
4. For appointment reminders. We may call or write you to remind you of appointments or to inquire about your health status.
5. For health-related benefits. We may contact you about new services, or educational programs we provide.
6. If contacted by coaches and teachers: We may give coaches and teachers limited information about appropriate activity restrictions.
7. As required by law. We honor subpoenas and other legal requirements to release medical information.
8. If you sign a release asking us to send information to anyone else.
9. During treatments: You may be exercising or receiving treatments with other patients in the vicinity.

YOU'RE RIGHTS REGARDING OUR MEDICAL FILES.

1. Right to copy and inspect. You have the right to copy and inspect your medical file. Copies are provided for $0.15 per page.
2. Right to amend. If you believe that information in your record is incorrect or if important information is missing, you may ask us to amend the information.
3. Please submit your request in writing to your therapist, and state the reasons for your request.
4. Right to an accounting of disclosures. You have a right to receive a list of instances where we have disclosed information about you for reasons other than treatment, or payment.

If you would like us to make exceptions to this policy, please ask.

______________________________ __________

Patient's signature Date